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ANNUAL REPORT

DECEMBER 1, 1966-OCTOBER 31, 1967



MIGRANT HEALTH PROJECT

(MG-56-C)

STATE OF
NORTH CAROLINA

NORTH CAROLINA STATE BOARD OF HEALTH
RALEIGH, NORTH CAROLINA



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NORTH CAROLINA STATE BOARD OF HEALTH MIGRANT PROJECT

(MG-56-C)

ANNUAL REPORT

DECEMBER 1, 1966-OCTOBER 31, 1967

DR. BURNS JONES - PROJECT DIRECTOR

N. C. STATE BOARD OF HEALTH

RALEIGH, NORTH CAROLINA

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INTRODUCTION

The North Carolina State Board of Health Migrant Project exists to facilitate the planning and development of migrant health programs by interested official and voluntary agencies in local communities throughout North Carolina. The project at the North Carolina State Board of Health has been made possible through support from a project grant from the United States Public Health Service Migrant Health Branch and supplemental funds and services provided by the North Carolina State Board of Health. The number of migrant workers migrating into North Carolina during each harvest season, their health needs; their patterns of motivation and their demographic make-up justify the needs for this project.

Each year from 12,000 to 15,000 migrant workers are employed in North Carolina. In addition, according to the records of the North Carolina Employment Security Commission many non-working migrants, such as older parents and very young children accompany the migrant crews. Due to an increasing trend in North Carolina to cultivate crops that can be harvested by women and children, more older children and working mothers accompany the crews.

The migrant seasons begin in the southeastern seaboard counties in May and reaches its peak in June. The season begins in the northeastern seaboard counties and moves over into the coastal plains area during the month of June. The peak seasons for these two areas respectively are June, July, and August. A small group of migrants returns to the northeast counties in October to harvest late crops. In Henderson County, in Western

North Carolina, the harvest season begins in June and lasts through October.

The majority of the migrants are Southern Negroes largely based in Florida with the next largest numbers coming from Mississippi, South Carolina, Alabama and Texas respectively. There are also some 6,000 North Carolina residents who cross-migrate from county to county within the state. According to information from the North Carolina Employment Security Commission intra-state migrancy is a growing trend in the pattern of migratory labor. This commission also reports an increase in the employment of Mexican Indians in the migrant labor field during the past year. Some growers are requesting the Mexicans because they are good workers.

North Carolina also has some seasonal farm workers migrating to Florida during the winter months to harvest crops. Nine crews were employed by Florida growers last year. The increase of out-migrants in North Carolina has definite implications for year round activities for the North Carolina Migrant Health Project. To provide services to meet the health needs of the workers who migrate into, out of and within North Carolina four migrant projects have been made possible through the support of grants from the United States Public Health Services Migrant Health Branch. These projects are located throughout the state in areas that are within the migrant stream. (see maps). Also other organized ways to meet the needs of this group are provided by county health departments in the areas of the state heavily populated by migrant workers. Services provided by these local projects and programs include medical health services, health education and sanitation services to improve environmental living conditions.

The North Carolina State Board of Health Migrant Project has a definite responsibility to all projects and programs throughout the state. That responsibility is to assist the projects and programs identify their needs, and on the basis of these needs to plan and implement functional programs. The state project objectives are:

1. To increase the effectiveness of existing programs in the the field of Migrant Health through consultation, demonstration, education and limited direct services.
2. To stimulate awareness of need and to encourage and assist in the initiation of Migrant Health Services in other areas where need exists.
3. To establish liaison between agencies and organizations, within and without the state, which are concerned with the health of migrants; to develop coordination between intra and interstate projects.

In order to carry out these objectives the State Board of Health Migrant Project has a team of consultants who will function as a resource to those agencies already operating migrant health projects and/or programs and other areas of the state that may need to provide services to the migrant population of their community. The role of this team may be described as follows:

(a) Sanitation -

An experienced sanitarian is employed to work with growers, crew leaders, health department personnel, and others concerned with the sanitation of migrant labor camps. His job includes

enforcement of state regulations regarding migrant camps, recently adopted by the North Carolina General Assembly. A second approach in this field is to encourage the local projects to employ sanitarian aides in their programs, who would help to advance camp and field sanitation through education and demonstration.

(b) Nursing -

A Public Health Nurse is employed to aid in setting up clinics, training staff members and implementing home nursing programs.

(c) Health Education -

A Health Educator is employed to provide consultation in public relations, in communications, and in education of migrants.

(d) General -

The State Board of Health team provides help in recruitment, orientation, consultation, and evaluation for local areas in need. The team provides coordination between local projects, and serves as a focus for the collection, tabulation, and analysis of information on migrants, their background, their needs, and the activities geared to meet these needs. In addition to their duties as consultants, the personnel from the State Board of Health is available to local agencies and organizations to provide direct services, particularly during peak seasons when supplementary workers are needed.

(e) The program of activities of the State consultants coincides roughly with the calendar year. Beginning in the late winter, the staff helps the local participating agencies and organizations in preparing programs, in recruiting personnel, in planning the set-up of services, and in the inspection of camp sites. Prior to the season, the project sites are visited to orient staff members and to coordinate activities. During the season, the clinics, day care centers, etc., are visited to offer consultation, advice, and implementation of services. Following the season, evaluative conferences are held. (Since migrants begin entering the state in May, and remain in some parts until November, there are about 7 months in the year in which the staff has been involved with on-site visits to camps).

(f) Throughout the year, the staff has been available for talks and meetings with concerned groups throughout the state, and to promote health services in areas not currently served by programs. Further, the staff assists communities in the design and structure of migrant health projects.

The remainder of this report is purposed to indicate progress made toward the realization of the State Board of Health Migrant Project's goals. The report includes examples of activities that support the project objectives and spells out into activities the functions of the consultant team. The activities of health education aides employed by the state projects and programs have also been included in this report in an attempt

to: first, point out the health education needs and medical needs of the migrant workers and secondly, to show how a lay person (sometimes referred to as aide type personnel in the health field) can contribute to the success of goal achievements in an official agency setting.

Another purpose of the following report of activities is to provide information that will be helpful to others as they plan activities to meet similar needs in migrant populations or other situations to which these kinds of activities may profitably serve as guides.

MAJOR MIGRANT STREAMS

JULY, AUGUST

OCT.

JUNE - OCTOBER
FLORIDA
(Western Stream)

ALABAMA,
MISSISSIPPI

MAY
AUGUST

FLORIDA, GEORGIA, SOUTH CAROLINA
(Main East-Coast Stream)

Intra-State Stream

Chapter I

STRENGTHENING EFFORTS IN MIGRANT PROGRAMS

Over 6,000 migrant farm laborers came into North Carolina to work during the 1967 harvest season, plus an equal or greater number originating in this state. The vast majority of these migrants lacked basic knowledge about matters relating to their health and welfare.

The objectives of the North Carolina State Board of Health Migrant Health Project spelled out into behavior means to help the migrant laborers and their families attain available health services, increase their knowledge of good health practices and to be motivated to voluntarily participate in health care programs available to them. These behavioral objectives are based on the premise that knowledge about health by the individual is essential to the community's ability to provide adequate health services and preventive care to its citizenry.

In order to achieve these behavioral objectives, as nearly as possible, the health education activities of the project have been concerned with facilitating the efforts of agencies responsible for providing health services by helping the individual migrant to: (1) know how to take advantage of health services offered (2) understand what good health practices are and (3) voluntarily participate for his own personal health and that of his family, and to initiate coordinated efforts of community

agencies for the improvement of migrant health services.

Six health education aides were employed by the state project and loaned to local health departments and local agencies with migrant project grants. The justification for providing this type staff was based on the premise that such additional personnel would help these agencies deliver available services to their incoming migrant population with less difficulty and make other needed services available which had not been provided previously.

The Health Education Aides had different educational and experiential backgrounds. One had worked as a Health Education Aide with this project during the summer of 1966, and holds a graduate degree in education. Another had worked as an Immunization Aide with another North Carolina State Board of Health program, and had some training in nursing. One was a housewife with a high school education; one was a ministerial trainee at the college level, and employed migrants as a grower. Another had some college training with experience as a helper in a migrant program in New York. One aide, employed to assist in the dental health program with a local migrant project, was a professionally trained dental assistant. All of the aides were selected by the local employing agency or project on the basis of their ability to do the job expected of them. This fact accounts for the variety of special competencies among them. Example: The dental assistant was selected because of the job expectation in dental health activities.

Three Health Education Aides were placed in local migrant health projects already funded by Public Health Service. Three Health Education Aides were placed in three different local health departments located in counties which had a great inflow of migrants but were without a migrant health service project grant. These latter counties were putting forth great effort, with limited staff, to meet their obligations to migrant workers. The State Board of Health project provided these additional staff members to ameliorate the burden on the local health department of providing health services to this addition to their population for such a short period.

The primary objectives for all the Health Education Aides were:

1. To make it easier for the health department or migrant project to improve the quality and quantity of services rendered to the inflowing migrant population. The following kinds of activities were carried out to bring about the realization of this objective.
 - a. Educating the migrants as to the health services available.
 - b. Helping the migrants understand the procedure or action to take to receive the services and when possible and/or necessary actually accompanying the migrant or members of his family to the resource offered.
 - c. Teaching migrants health facts to increase their knowledge about health and profitable health practices.

d. Informing them about educational opportunities provided in the community for themselves and their children such as day care centers, kindergartens, public school and adult classes.

2. To make it possible for the health departments or migrant projects to provide the migrant population other services not previously offered.

A. EXAMPLE: HEALTH EDUCATION AIDE ACTIVITIES IN DENTAL HEALTH TO
PROVIDE NEW SERVICES

The migrant health projects are attempting to provide as many health services to the inflowing migrant population as possible. The local health migrant health project in the Albermarle area expressed a need for an aide in providing dental health service. The State Board of Health Project extended the health service arm of this one project by placing a Health Education Aide on their staff who had been trained as a dental assistant. This staff member worked under the supervision of a public health dentist employed by the project. It was the intent of the state project when it provided this staff member to help the local project strengthen its dental health services.

The duties of this aide included:

1. Conducting education programs regarding dental health with parents, children and their teachers. These activities

were to take place in such physical settings as day care centers, kindergartens, public schools accommodating migrant children, health clinics and camp sites.

2. Performing preventive dental services under the supervision of a public health dentist such as (a) demonstrating cleaning methods to groups and individuals and (b) giving topical fluoride treatments.

The interesting aspects of this example of services are that it was an attempt to make health services to migrant workers more comprehensive, but even more important, it also focused on preventive care. It was an attempt to connect this health practice of the migrant with long range goals or preventive measures rather than to wait until an immediate need was painful enough to demand attention.

We do not propose to list numbers here as an evaluation of this project. We will base our evaluation on the premise that involvement and experiencing are good teachers. Children and adults, through this service, had pleasant experiences with dental health treatments and dental health personnel that they themselves were happy about. We term this project a success. Cooperative plans have already begun with the State Board of Health Migrant Project and the State Board of Health Dental Health Division to further extend these services.

B. EXAMPLE: HEALTH EDUCATION AIDE ACTIVITIES TO STRENGTHEN SERVICES
IN LOCAL HEALTH DEPARTMENT

Physical distance and time tables for clinics can be a complete barrier to rendering services to migrant workers. This is an example of what one health education aide did to solve this problem in a local health department without project funds.

The health education aide held many conferences with individuals and groups regarding health services available to them from the health department. Very few participated. The health aide discussed with the migrants what they themselves saw as problems preventing them from attending clinics and getting other services available. The most pressing problems listed by the migrants were transportation and time schedules set for the clinics.

To attend the clinic during routine hours would not only work a hardship on the migrant, in that he would lose his opportunity to earn money during the daylight hours, but also the farmer employer would be displeased at the loss of time in gathering his crops at the most profitable time to gather and to market.

Therefore, to alleviate this situation, the health education aide planned with his co-workers at the health department to schedule a clinic for migrants during the evening hours when they could attend. The clinic offered the following services: X-rays, tuberculin testing, serology tests, and other vaccines and/or immunizations as needed. Follow-up procedures

were conducted as for any other clinic. Retesting was done where necessary and the proper referrals were made.

Two clinics were held with approximately 80 migrants attending the two clinics. Aside from the migrants seen in the special clinics the health education aide also referred 5 (five) to private physicians who gave them the medical care needed, and 10 (ten) others were able to attend the regularly scheduled clinic of the local health department.

The clinics were staffed by volunteers from the regular health department staff, nurses, clerks, the health education aide and sanitarians. Also joining the staff were the district venereal disease investigators, nursing personnel from the North Carolina State Board of Health and the local Office of Economic Opportunity Program. The local staff from the North Carolina Council of Churches Migrant Project also participated.

Other interested citizens, representing local civic and social clubs, volunteered to serve as a receptionist at the clinic, to furnish and serve refreshments and to provide transportation where needed.

The significant factors about this sample of activities of a health education aide with a migrant project are:

1. This was the first time a health clinic had been scheduled for the inflowing migrant workers to this county at an hour most convenient for them to attend.

2. The migrant workers themselves had been involved in the planning.
3. The health department has experienced departing from routine to serve a segment of the population whose needs demanded a new style of operation. This experience in new ways of rendering services to migrant workers lends itself to planning for segments of the county's own underprivileged working population that may need special hours for services.
4. What may be most important of all was the local health departments' opportunity to make some of the local citizens aware of the health needs of migrant workers, the community's responsibility for meeting these needs and the kinds of community resources necessary to meet them.

C. EXAMPLE: OTHER ACTIVITIES OF THE HEALTH EDUCATION AIDE

All of the aides initiated and carried out some or all of the following activities:

1. Demonstration of ways to prepare and use inexpensive foods
(Example: dry milk)
2. Securing the services of and cooperating with local farm extension service personnel to:
 - (a) help the meal planners and cooks in the migrant camp kitchens to plan and prepare inexpensive, nutritious and balanced meals.

(b) demonstrate how these meals may be prepared with the meager cooking facilities available in the migrant camp.

3. Planning and improvising better storage practices for food products in order to protect from rats and prevent waste.
4. Conducting meetings with groups of migrants regarding the mid-day meal which was sometimes picked up at the country store. The purpose of this activity was to help migrants improve their selection of the kinds of foods necessary to meet the body's nutritional needs for the day.
5. Working with children and staff in day care centers and public schools for migrant children. (Example: prepared health posters on safety, nutrition, and dental health and gave some health talks to children).
6. Distributing material on the above subjects and material on child care to parents in migrant camps and to teachers in day care centers and schools.
7. Showing and making available health films and film strips to teaching staffs.

8. Informing parents regarding the availability of day care centers and schools for their children and assisting them in getting the children enrolled.
9. Demonstrating to children proper ways to brush their teeth.
10. Working with agencies such as the Welfare Department and local O.E.O. offices to provide clothing to migrant children and adults in need of them. (Example: clothes closets).

In the health department setting the aides:

- a. Served as hostesses in evening clinics to assist patients.
- b. Held informal conferences with individuals while they waited to be served in the clinic, many times discovering information important to the attending physician or nurse that was not already on the record.
- c. Followed through on patients who did not keep appointments at clinics and made new appointments.
- d. Drew maps to show most convenient route from camps to the health department, clinic or mobile trailer clinic stations.
- e. Informed migrants of clinic schedules and posted written schedules on camp sites for both the mobile trailer clinic and local health department clinics.

A listing of the activities of health education aides falls far short of telling the whole story about the worth of allied health personnel working

in an official agency program. It is the belief of the health educator with this project that the health education aide working in migrant programs in local health departments have demonstrated the usefulness of this type of allied health personnel on local health department staffs. This is especially true in implementing programs geared to meet the needs of the poor.

D. EXAMPLE: COLLECTING DATA --- SURVEY OF NORTH CAROLINA BASED MIGRANTS

It has become increasingly evident to those working with agricultural migrants in this state that we are meeting more and more of our own resident North Carolinians working away from their homes in the harvest. These intra-state migrants in 1967 numbered some 5000-6000 workers, many accompanied by their families. These North Carolina residents while "on the season" are subject to the same working and living conditions of the inter-state migrant and to many of the same health problems. Being away from their own homes and familiar surroundings they seem to be, in most instances, as unaware of the health and welfare resources available in their temporary working areas as the person from another state, and may be subject to some of the same restrictions about receiving services because of their non-residency status in the county. These 5000-6000 workers come from 32 (thirty-two) North Carolina counties (see attached list) and work in some fifty counties in the harvest of tobacco, garden crops and fruit. Many of these workers and crewleaders travel on to other states, therefore working as inter- as well as intra-state migrants. The formation of more agricultural crews is being

encouraged by the Farm Placement Bureau of the Employment Security Commission so that an increase in the number of the North Carolina based migrants can be anticipated.

Do these North Carolina intra-state migrant workers have special needs that the Migrant Health Project can help to meet? Could this group of people, because of their accessibility to the project staff during the winter months be helped to prepare themselves better for the "migrant stream"? Are these North Carolina migrants an identifiable group, and if so, what are some of their characteristics? These are a few of the questions that came to the minds of the project staff in trying to determine what plans should be developed for this group.

The interest of the project staff in these intra-state migrants grew, and as it became increasingly evident that we knew very little about these workers, plans were made to collect information about them by means of a survey. The objectives of this project were outlined as:

1. to identify the work characteristics of seasonally employed migratory agricultural workers who are residents of North Carolina.
2. to identify patterns of health care of this group and their families.

With the assistance of consultants from the School of Public Health, University of North Carolina, a questionnaire was developed for testing.

A Duke University student, assigned to work with the Migrant Health Project by the Governor's Internship Program, administered a test questionnaire early in July. Based on the findings of the test survey, a revised questionnaire was adopted in late July. It was designed to gather information on demographic characteristics, travel patterns, employment patterns, make up of household groups and knowledge and utilization of health resources. The revised questionnaire (see appendix) was administered to 64 (sixty-four) intra-state migrants in 11 (eleven) crews. In each of these 11 (eleven) crews one person in each household was designated as the respondent.

Information from these 64 (sixty-four) initial respondents was tabulated by data processing and the results are presently being studied by the project staff with consultants from the Vital Statistics Section of the State Board of Health. If the results of this preliminary survey show that the information gathered about this group is of value, and that this survey method is an effective way to gather the needed information, it will be continued on an expanded scale.

The major objective of this survey was to provide data essential to the operation of an effective migrant health program in North Carolina. The health needs of those North Carolina residents who enter the migrant stream are of concern to all those involved in planning health programs in this state. By identifying the members of this group and assisting them to recognize the importance of achieving and maintaining a healthful state, the migrant program can make a major contribution.



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NORTH CAROLINA HOME-BASED MIGRANT WORKERS

<u>COUNTY</u>	<u>HOME BASED MIGRANT WORKERS</u>	<u>COUNTY</u>	<u>HOME BASED MIGRANT WORKERS</u>
Beaufort	115	Johnston	125
Bladen	200	Madison	100
Brunswick	100	New Hanover	125
Buncombe	200	Northampton	250
Chowan	125	Pender	115
Cleveland	200	Ferson	100
Columbus	105	Rockingham	100
Cumberland	115	Robeson	150
Duplin	105	Rutherford	300
Durham	125	Sampson	300
Forsyth	175	Transylvania	200
Guilford	150	Wake	150
Halifax	125	Washington	100
Haywood	250	Wayne	350
Henderson	250	Wilson	125
Hyde	100	Yadkin	105
		TOTAL	5135

Chapter II

CONSULTATION AND SUPERVISION

Sanitation

The Project Sanitarian, other personnel of the Sanitary Engineering Division, North Carolina State Board of Health, local health department sanitarians, and others continued the types of activities described in previous reports. Briefly, these consisted of cooperative and educational work with growers, crew leaders, migrants, the Employment Security Commission, and other agencies with the objective of achieving acceptable levels of sanitation in migrant housing by salesmanship and without court action. However, the program has now progressed to the point that court action will be initiated if and when necessary. Inspections were made of camps before occupancy and permits were issued after compliance.

We feel that adequate levels of sanitation were maintained in the authorized camps as the result of these activities.

In the Project application for 1966-1967, it was proposed that the Project Sanitarian would devote only part of his time to Project activities, and that much of his former routine work would be handled instead by the District Sanitarians of the Sanitary Engineering Division as part of their regular activities. In implementing this change, which was included in the 1967 Sanitary Engineering Division program plans, conferences were

held with the District Sanitarians; and the Chief, Sanitation Section, SED, and the Project Sanitarian made pre-season visits to camps with several of the District Sanitarians. Satisfactory progress with this transition is being made. Effective July 1, the Project Sanitarian transferred to another program in the State Board of Health; a replacement has been selected and this will be announced at or about the end of the Project year. In view of this transfer, it was fortunate that the previously-mentioned transition was already in process.

Because of the transfer of the Project Sanitarian to other activities, it was not feasible to compile certain data included in previous reports. The following statements are based upon field observation, inspection reports from local sanitarians, and written and verbal reports from the District Sanitarians.

Permits were issued to 101 camps housing 10 or more workers and subject to the law. These authorized camps were located in 18 counties as shown in Exhibit A. A few others, including 2 in Transylvania County, operated and substantially complied with sanitation standards but permits were not issued because of technicalities and these were not counted as authorized camps. Reports indicate that approximately 3,400 workers were housed in the camps, but it is believed that the actual number was greater. The same reports indicate that, in the same 18 counties, approximately 1,000 workers lived in housing units in groups of 9 or less.

Routine inspections of the authorized camps by the local and State sanitarians indicated substantial compliance. A review of the inspection reports shows that the sanitation scores were distributed as follows:

<u>Range of Sanitation Scores</u>	<u>% of Inspections in Specified Range</u>
90.0 or Above	31
80.0 to 89.9	48
70.0 to 79.9	19
Below 70.0	<u>2</u>
Total	100

Based upon experience in the scoring and grading of public lodging and foodhandling establishments, we believe these data show that generally acceptable conditions were maintained.

We are of the opinion that the tendency toward improvement of housing for groups of 9 or less workers, as noted in last year's report, has continued. We do not have data to support this statement, and it was not feasible to give special emphasis to such housing during the year as originally planned. However, there is increasing awareness of the need for basic sanitation facilities regardless of the size of the group being housed, and we would be surprised if the trend toward up-grading of housing did not continue.

Partly as a result of demonstration units discussed in last year's report, some improvements in field sanitation have been made, including the placing of 88 sanitary privies at locations other than the authorized camps.

We continued to give technical assistance to the Project and assisted in the orientation training of 16 Sanitation Assistants employed by the Project and assigned to counties to work under the direct supervision of the local sanitarians. This included participation in the pre-season orientation conferences, and a 2-day school for Sanitation Assistants on water supply protection and sanitary privy construction.

The Project Sanitarian and the District Sanitarians conducted one week of instruction at each of two 10-week schools for crew leaders. These schools, financed through MDTA funds, were held at Department of Community Colleges facilities in Robeson and Wilson Counties during the first three months of 1967. Twenty North Carolina crew leaders attended each school. The material on sanitation was well received and we have reason to believe the lessons learned have been put into practice. One crew leader reported later that he had bought another home because our men made him feel ashamed of the place he had been living in. There have been no reported complaints regarding failure of these crew leaders to maintain properly the housing provided them this season.

CONCLUSIONS

1. The level of sanitation maintained in the camps housing 10 or more workers was generally acceptable.
2. The condition of housing units for groups of less than 10 migrants has continued to improve, but much remains to be done.
3. Some progress was made in improving field sanitation. As noted in last year's report, we believe that convincing arguments for such improvements have not been developed.

4. The principal reasons for the improvements made during the last four years were listed in last year's report and are repeated below:

a. We sought and received the active support and cooperation of the local health directors and sanitarians.

b. We solicited and gained the understanding and interest of the growers as to the common-sense need for providing facilities that comply with basic sanitation standards. This was accomplished mainly by personal visits and discussions.

c. In most camps, we were successful in getting the crew leaders to assign "yard men" the responsibility for routine cleaning and maintenance of the camp area. This included "policing" the grounds, daily cleaning of toilet facilities, minor repairs, and daily operation of garbage "landfills." The "yard men", being present at the camps during working hours, became the "contact men" for the Sanitarians and Sanitation Assistants. Also, the "yard men", because of their duties, effectively prevented vandalism; this is important to the growers who provide the facilities.

d. In several communities, the community leaders were made aware of migrant labor sanitation as a community problem (flies, disease, crime, etc.), and they became actively engaged in helping to alleviate some of the problems. As a result, their attitude toward migrants changed from one of intolerance to one of understanding and helpfulness.

e. The cooperation of the Employment Security Commission and its field representatives continued to be excellent.

f. Although difficult to evaluate, there were definite indications that migrants were responsive to the assistance and better facilities provided them, and it is believed that this is a reflection of their

being increasingly recognized as individuals and citizens.

5. The transition discussed earlier in this report is proceeding satisfactorily and the District Sanitarians are assuming their migrant labor sanitation responsibilities satisfactorily.

OBJECTIVES FOR 1967 - 1968

The past activities and approaches, which have been found to be successful, will be continued with relatively minor changes. We propose to:

1. Continue the transition previously discussed whereby the District Sanitarians assume much of the activity formerly handled by the Project Sanitarian. A District Sanitarian will be appointed as Project Sanitarian to serve on a part-time basis; the selection has been made but not announced.

2. Actively promote more effective pre-season compliance checks and issuance of permits before workers arrive.

3. Give special attention to promoting needed improvement in housing units for groups of less than 10.

4. Cooperate with Employment Security Commission in implementing housing inspections required by revised policies of the U. S. Department of Labor.

5. Continue active cooperation with, and assistance to, the other agencies and groups concerned with migrant labor sanitation, including Employment Security Commission and N. C. Council of Churches Migrant Project.

Health Education

The health education consultant with the state project spent most of her time in the field working with staffs concerned with migrant programs. This included training, and supervision of health education aides and also consultation with other staff members of the local health departments carrying out migrant health programs and/or other local agencies carrying out migrant health projects.

Two migrant health projects have project coordinators. One was employed for the first time this year. In order to help the project coordinator function as effectively as possible the health education and nursing consultant prepared some Guidelines for the Coordinator of the Carteret County Migrant Project (see appendix). The health education consultant and the nursing consultant from the North Carolina Migrant Project discussed these guidelines together with the project director and the project coordinator and decisions were made as to how these guidelines could be implemented.

Two of the migrant projects in the state employed professionally trained health educators. One of these projects was unable to find a professionally trained health educator for such short term employment (3 mos.) Therefore, a person with a college degree, in an allied field, was employed as a non-professionally prepared health educator. This employee was expected to function beyond the level of a health education aide but was not expected to function at the same level or perform the

same kinds of activities at the same level as a professionally trained health educator. Therefore, during the orientation of the staff of the local project the health education consultant at the State Board of Health Migrant Project consulted with the health educator and the project director regarding the role definition of the non-professionally prepared health educator.

Some suggested guidelines to follow regarding the health education activities were prepared. (See appendix for guidelines for Non-Professionally Prepared Health Educators). In the light of the over-all goals and the health education goals of the project the project director and health educator set priorities for health education activities.

Each health education aide and health educator employed by local programs sent reports of their activities to the state office. These reports were reviewed by the state staff, discussed with the health education aides and health educators. When it seemed profitable to encourage the strengthening of any of these activities it was done. If there was reason to believe they were not productive of positive results they were discouraged.

Several field visits were made to migrant camp sites and to health clinics together with the health education aides and health educators. Situations that provided opportunities for health education activities were observed there and various kinds of health-education activities were suggested in some of these situations. In some instances demonstrations were given on the use of educational tools adaptable to

education purposes in a given situation.

The state staff, upon invitation from the director or coordinator participated in the staff conferences of the local project personnel. During these conferences health education objectives were discussed to assure better understanding of the health education goals of the project, and what other staff members could expect from the health education aide and/or the health educator staff member of the project. The staff members suggested ways of coordinating their activities.

One joint conference was held with the local project staff members and staff members of other agencies involved in migrant programs in the same community. The other agencies represented were the North Carolina Council of Churches, public welfare, and representatives from the Migrant Health aspect of the North Carolina Department of Public Instruction (Elementary, Secondary, Education Act). This conference was part of the orientation for the health education aide and project coordinator. Strong support is given to this type of joint staff planning. It provides opportunity for the kind of planning that will eliminate overlapping or gaps in services rendered. Services offered by each agency were discussed and ways to coordinate staff activities were planned.

Field visits were also made to counties in the state without migrant programs. The purpose of these visits were:

1. To arouse awareness, on the part of public agencies, of the number of migrants entering the community during the harvest season

2. To stimulate these agencies to consider the needs of these migrants when they investigate the community's needs for health services and make plans to meet those needs.

The major effort of the staff activities on the field was to provide consultation to staff members regarding their problems and concerns about fulfilling the objectives of their program for migrants. Our assistance was given in securing materials or locating sources of materials helpful in health education activities of the local program. Opportunities to plan with staffs to initiate practices that enrichen on-going programs were deliberately sought out and developed.

Health Education COSTEP

A Health Education COSTEP and a Nurse COSTEP were assigned to the Albemarle Migrant Project by the Migrant Health Branch of the U.S.P.H.S.

The health education COSTEP did not visit the State Board of Health before going to his assigned area. However, during his orientation at the local project to which he was assigned the health education consultant, State Board of Health Project discussed the objectives of the State Migrant Health Project and their implication for health education objectives. Also the health education goals of the local project were discussed by the entire staff; lines of communication between education staff and the other staff members were discussed and examples of cooperative efforts to achieve program goals were cited.

It was made possible for the Health Education COSTEP to make some initial visits to the camps sites, local community agencies concerned with migrant programs and become acquainted with some key persons outside the project staff.

The End of Assignment Report of the Health Education COSTEP held significant observations that, in the Health Education Consultant's opinion, should be evaluated thoroughly by those who plan migrant programs to ascertain the degree of validity to such observations. Thought and consideration should also be given to these observations when setting goals and objectives for planning and developing program content for migrant programs.

The health education consultant asked the health educators in each project to evaluate materials they used including the materials developed by this project in 1966.

This is what the Health Education COSTEP had to say about these materials.

"One of the basic problems with these printed materials I have seen thus far is that in no way do they depict what the migrant laborer is coming in contact with. The environment is all wrong, artifacts are all wrong, colors are all wrong, the message is all wrong; for these components do not allow migratory workers and their families to identify with that which is in their environment. The health education materials I have reviewed are made up originally for a different audience or else they are quite inadequate for our purposes."

Another comment made by the Health Education COSTEP Migrant Health programs is quoted below.

"The leader, not only economically, not only organizationally, but also, from what I've seen, physically, is the crewleader. I mean these men are big. They are leaders in the sense that they have people following them. The extent that the crewleader has all this power and is given certain priorities by the Migrant Health Project staff as well as by the people he has brought with him, it is quite difficult to develop potential leadership, in its classical sense, within the migrant population.

In fact, developing leadership would probably be antithetical to some of the presuppositions regarding social change under which the Migrant Health Project is now operating. Most of the people I have observed have been people who have come out of the bowels of our economic system. They don't have a skill. They are Wine Ohs or alcoholics. Most of them are older men. Not many families come. The following is what someone told me the other night at the clinic:

"A crewleader goes into some of the bars in Florida buys people a bottle of wine tells them to sit in the bus over there and have an easy drink then hijacks them. Before they know it they are a couple of hundred miles from where they live."

These are some more workers for the Eastern Migrant Stream.

Now, if the above narrative is, in fact, true and if one presupposes that a good many of the people are and are going to remain Wine Ohs, alcoholics and the like, there is very little leadership available for development, practically speaking, within a six-week period of time. However, this is not to deny that some of the migrants laborers are very capable and smart."

The North Carolina Migrant Health Project had for its objectives regarding the Health Education COSTEP to:

1. Provide opportunities for the Health Education COSTEP to gain more understanding of the problems facing local and state program planners for the improvement and maintenance of the health of its citizenry.

3. Experience working as a team member of a staff concerned with one particular segment of the population which presented problems requiring initiative and vision out of the realm of ordinary procedure to solve.
4. To receive from the Health Education COSTEP new and productive ideas to aid these staff to plan more appropriate and realistic goals and program content for migrant programs.

Public Health Nursing

Field visiting is one of the major means used by the consultant staff of the Migrant Health Project, North Carolina State Board of Health to work within the overall objectives of the project. These field visits to assist individuals and groups working with or interested in working with migrants make up a considerable amount of the activities of the nursing consultant.

Some ten visits were made to local Public Health Service funded projects during the winter and spring months to assist in the evaluation of previous programs and in the planning for the 1967 season programs. During these visits time was also spent developing and discussing guidelines for project personnel and plans for the employment, orientation and training of the staff members. In addition to these field visits twenty-seven consultation days were spent with the local project staffs during the active season in working on specific problems which arose during the program activity. The visits were spent in working with the project nursing staff primarily, but additional time was spent with the other disciplines when the consultant could be of assistance. The directors and coordinators of the projects often requested assistance with administrative questions, and the new reporting forms brought many requests for help from the clerical staffs.

Attending staff conferences, accompanying nurses on field visits and attending clinic sessions were some of the methods which were used to become as familiar with the local situation and project facilities as possible. As 1967 was this consultant's first "season" with the migrant program, this was essential to be of help in planning for the implementation of an effective nursing program. The local project nurses, many without previous public health experience, often requested the supervisory guidance of the consultant in their field visits and in the clinic activities. Joint field visits were made in most areas and a caseload review was done where appropriate. The planning of daily activities, determining and setting priorities, and recognizing limitations were common difficulties which the local nurse brought to the consultant. Record keeping continues to be a major problem for the nurse in the local migrant health. Much more time needs to be given in orientation and training periods to the use and importance of record keeping. In addition, the development of more adequate record forms will be a major consideration of the staff of this project during the coming winter.

One of the problems which arose in two of the local projects brought about the necessity for the project staff to do some serious reconsideration of their personal as well as project objectives. This problem is one which will probably occur in all the local projects eventually, and can cause a serious dilemma unless the staff recognizes and copes with it. Two local projects found that over the past few years the migrants coming to their

counties have come to expect and desire a high quality of health care, and have become more oriented to seeking preventive health services. This meant that in addition to the group normally coming for treatment of acute or chronic illnesses, many more migrants were asking for routine physical examinations, X-rays, immunizations and blood tests. And their own previous exposure to migrant health programs led them to seek this care more self-assuredly and to be leaders in bringing other migrants to ask for this kind of health care. These factors often led to clinics previously averaging 15-25 patients having an attendance of 30-50 people, 3-4 nights weekly, resulting in clinic sessions lasting from 4-7 hours, often going on until well after midnight. In these two project areas personnel were working 12-16 hours each day staffing the evening clinics and doing the follow-up in the field the next day. Because it was evident that the increased responses to the health clinics, though welcome, was presenting more of a problem than poor attendance ever had, staff meetings were called in both projects to discuss what this would mean to the project operation. The nursing consultant was invited to participate.

A very simple answer to the dilemma seemed to be to employ more personnel. Budgetary restrictions as well as the shortage of available medical personnel did not make this a total answer. However in one project an additional registered nurse and physician were employed. Restricting the clinics to those who were "sick" was an obvious solution to some.

They could see a method developed for screening out those who were healthy from those who were sick. Others, especially those who had worked previously in the migrant program, objected strenuously to this solution. They felt they had spent several seasons teaching the migrant worker the value of and need for preventive services, and now if he asked for these services he would be turned away. Why then had they been told that this teaching was an important part of the program? Were they teaching the migrant to expect and desire a service that would not be available when he asked for it? What would the migrant's reaction to this be? Would the trust the staff had worked so hard to develop be another disappointment in the life of the migrant. And they wondered who would take the responsibility for deciding which patient requesting service was sick and which was "too healthy" to receive care. Many cases of borderline hypertension, diabetes and tuberculosis were found in patients who presented no physical complaints on initial interview. Many women had had Pap smears on their routine physical exams which proved to necessitate extensive medical care. And, the staff felt an immeasurable amount of health teaching had been accomplished just in providing the opportunity for contact between the migrant and the health personnel in a favorable setting. The objectives of each project and each staff member had to be examined in their study of this problem of increasing demand for service. When this had been done the decisions made indicated that none felt that the objectives could be reached by restricting services. Once this decision had been made, other plans to make the situation workable for the staff members while continuing to meet the need of the migrant worker and his family

had to be developed. Work schedules to avoid some of the consecutive "long" days were tried, utilization of project personnel was studied, and auxilliary personnel were given additional training and responsibilities in one project. Plans were made to utilize more effectively the interviewing skills of the professional personnel, assisting the movement of the patient to the right resource within the clinic. Through staff conferences and the willingness to try new ways to provide service these two projects were able to adjust to meet the increased demand for health care without compromising their overall objectives. In the evaluation of the 1967 season additional consideration of what this increased demand meant to the program is needed. Whether quality of health care was or has to be affected by the increase in quantity demanded may be difficult to determine, but this question deserves serious thought.

Although the role of consultant and supervisor does not often offer much opportunity for participating in the actual giving of a direct service to the migrant, there was an opportunity to do so this summer in a migrant clinic offered by a county not normally providing special health services to migrants. This health department held two evening clinics offering immunizations, tuberculin skin tests, blood tests and chest X-rays to the migrant workers employed in their county. The nursing consultant from this project, as well as the nursing consultant, Tuberculosis Control Section, North Carolina State Board of Health, assisted the staff of this health department in the clinic. The opportunity to work again

directly with the patient was a thoroughly enjoyable experience, and the opportunity to work with the health department staff and local citizens, all of whom had volunteered their time and services, was especially satisfying.

One other major objective of this project is to stimulate awareness of the need for services for migrant workers in areas where no formal migrant health program is in existence. In conjunction with this objective, visits were made to seven counties to familiarize the staffs of these health departments with the health problems of the migrant worker and his family and some of the resources available to the county in helping to meet these needs. The interstate referral system and the Personal Health Record (PHS 3652) were introduced and their use discussed. Additional assistance was offered to those counties who expressed interest. At this time health records and interstate referrals are available in and being used by 33 counties in North Carolina.

Nurse COSTEP

The assignment of a Nurse - COSTEP to work in the migrant health programs in North Carolina was made by the Migrant Health Branch early in June. The Nurse - COSTEP, a senior nursing student from California, was assigned to the Albemarle Migrant Health Service Project which serves five counties in northeastern North Carolina.

The initial orientation to the statewide programs for migrants was given during the COSTEP's first week in North Carolina. During the four days spent at the State Board of Health Migrant Project office there was an opportunity to discuss the objectives of the Migrant Health Project and the ways in which this staff worked with the local Public Health Service projects as well as the programs of other agencies working with migrants. An introduction to the general program and functions of the Public Health Nursing Section, North Carolina State Board of Health was also provided by Miss Elizabeth Holley, Section Chief and several of the generalized nursing consultants.

During the COSTEP's assignment to the Albemarle project direct supervision was provided by the public health nurse working in the project and the generalized nursing consultant in the project area. Plans were made with these two nurses and the Migrant Health Project Nursing Consultant for the student to participate in the field and clinic activities of the Albemarle program. Opportunities were also provided for the student to

observe the activities of the local health departments in the area providing a more complete picture of public health nursing at the local level.

The opportunity to have students in the migrant programs in North Carolina, including those in medicine, nursing and health education, offers several advantages. It offers the project staffs the stimulation that students offer by their questioning and learning approach to their new experiences. It allows those working in the public health and welfare programs an opportunity to demonstrate to professional newcomers the challenges and satisfactions available in service programs. And it offers those of us interested in the welfare of the migrant worker and his family an opportunity to help these students understand the need for the programs directed to the migrant, and to solicit their support and their help.

TRAINING EFFORTS

The North Carolina State Board of Health project provided two formal training conferences for personnel working with migrant programs. They were:

1. THE THIRD ANNUAL NORTH CAROLINA CONFERENCE ON MIGRANT HEALTH and
2. THE MIGRANT HEALTH TRAINING WORKSHOP

The state project cooperated by participating with the North Carolina Employment Security Commission in a Training School for Crew Leaders and with the North Carolina Council of Churches in an Orientation and Training Conference for members of their Field Staffs.

I. THE THIRD ANNUAL NORTH CAROLINA CONFERENCE ON MIGRANT HEALTH

The Third Annual North Carolina Conference on Migrant Health, sponsored by the Migrant Health Project, North Carolina State Board of Health, was held in the spring of 1967. This year's conference was co-sponsored by the North Carolina Council of Churches' Migrant Project (ECA III-B). These two projects, sharing the common objective of improving the life of the agricultural migrant worker and his family, used the opportunity of this joint effort to renew their efforts in soliciting the continued interest and support of other official and voluntary organizations interested in working with the migrant.

The conference planning committee included representatives from federal, state and local agencies and organizations concerned with the welfare of the agricultural migrant worker and his family. Besides the staffs of the two projects, the committee was composed of representatives from the North Carolina Employment Security Commission, United States Public Health Service Migrant Branch, Region III, the Agriculture Extension Service of North Carolina State University, the Department of Public Welfare, the Department of Public Instruction, the Department of Mental Health and local United States Public Health Service Migrant Health Projects. The theme of this year's conference, "Barriers to Effective Understanding", was chosen because of the intense need felt by those persons who were working with the migrant laborer to improve their ability to communicate effectively with a group whose values and needs were so often not understood by those in the so-called "helping professions." The objectives of the conference were set forth as follows:

1. To recognize and analyze cultural barriers to effective understanding and personal barriers to helping.
2. To explore the process of effective communication and its effect on increasing the understanding of common goals and shared values among individuals, groups and organizations.
3. To familiarize agencies and individuals with new services for migrants and new developments in existing programs.

Through the kindness of Miss Helen Johnston, Chief, Migrant Health Branch, United States Public Health Services, the services of Dr. Sam Schulman, Professor of Sociology, Colorado State University and consultant to the Migrant Health Branch, were made available for the conference. Dr. Schulman's keynote address, "Barriers to Effective Understanding" (see appendix) set the tone for the meeting, and small group discussions and role playing situations were used to build on the insights and ideas brought out by Dr. Schulman. Other speakers added to this theme of the need to increase understanding, including Mr. Tom Roberson, former Health Education Consultant, United States Public Health Services Migrant Health Branch. Mr. Roberson related the experiences of his youth to the similar needs of the migrant for self-identity, and increased the group's sensitivity to this very common need. (see appendix)

Seventy-three people attended this two-day conference held at the Betsy-Jeff Penn 4-H Camp in Reidsville, North Carolina. These participants represented federal, state and local agencies and organizations interested in the agricultural migrant and in improving the services they are providing for the migrant. The general reaction to the conference was that it provided an opportunity for sharing of ideas and philosophies about mutual concerns with colleagues and co-workers.

II. THE MIGRANT HEALTH TRAINING WORKSHOP

The Migrant Health Training Workshop was sponsored by the North Carolina State Migrant Project, State Board of Health. It was designed for clerks, nurses, clinic aides, health education aides, project coordinators, and project directors in local projects and local health departments with migrant programs.

The objectives of this workshop were to:

1. Acquaint workshop participants with the overall purposes and history of migrant health programs including national, regional, state and local.
2. Show the specific relationship between the state and local migrant health projects.
3. List and highlight the major health problems of migrant workers in health areas such as: nutrition, safety, sanitation, social services, and the lack of general health knowledge necessary to attain services and to practice healthful living.
4. Help the participants to understand the meaning of health, and health education.
5. Understand some of the learning styles of migrant laborers.
6. Interpret further the specific roles of the participants by involving them in some of the functions they would be expected

to perform. Example: Interviewing techniques, education methods, record keeping, referral systems and reporting.

7. Improve their communication skills.

The workshop organization was patterned by the small working group -- general session plan. The participants were divided into small groups according to discipline so that they could learn about duties and responsibilities relating specifically to their role. General meetings were scheduled when subjects of discussion and/or activities were relevant to all of the participants. It was a training workshop as the title implies. The content was devoted to the kinds of activities the workers would need to be doing and why these kinds of activities are necessary in a migrant health program.

The workshop participants consisted of three clerks, four nurses, four clinic aides, six health educators, one project coordinator and one project director. The workshop staff consisted of personnel from the North Carolina State Board of Health with representation from the following departments: Nutrition, Health Education, Dental Health, Nursing, Tuberculosis, Sanitation, Records, Film Library, and the Training Task Force. Workshop staff members were also from the North Carolina Council of Churches' Migrant Project and the North Carolina Department of Public Instruction, Audio Visual Aids Department. From the local level services were secured from the Guilford County Health Department, Greensboro, North Carolina.

Verbal comments by the participants related that the workshop had been profitable. During follow-up visits to the field by the State Board of Health Migrant Project staff many of the methods of health education were being practiced; clinic procedures recommended were being followed and much of the health education content included in the workshop was being taught by the staff workers.

III. ORIENTATION AND TRAINING CONFERENCE FOR FIELD STAFF MEMBERS OF THE NORTH CAROLINA COUNCIL OF CHURCHES' MIGRANT PROJECT

In cooperation with the North Carolina Council of Churches' Migrant Project (EOA III - B) the staff of the Migrant Health Project participated in the orientation and training conference for 89 of their field staff members in May. This conference was held to orient those staff members who work in the sanitation, day care and social service programs of the North Carolina Council of Churches' Migrant Project.

As an introduction to the conference an overview of the activities and objective of the Migrant Health Project, North Carolina State Board of Health, and the local Migrant Health Services projects was given by the director of this project. During the same morning the participants heard the health education and nursing consultants discuss the services available to the migrant and to those working with the migrant through the Public Health Service funded projects. As has been continually true in the association of these two programs, emphasis was directed on the ways in which all those working with the migrants could use the available resources cooperatively.

The channels of communication between the two programs have operated effectively at all levels in past years and effort was made at this conference to keep the workers up to date on all resources available to them.

At a later time in the training program, the nursing consultant and the health education consultant met separately with the homemakers who work in the social service component of the project. These sessions were designed to discuss specific health and teaching problems which would occur in the process of the homemakers daily activities. These sessions also served as opportunities to provide a personal basis for future encounters, and to reinforce the relationships between those working with the migrant. The staff of the North Carolina of Churches' Migrant Project working in the local area have always been cooperative in their relationship to the staff of the Migrant Health programs and have extended our health program through their activities as sanitarian aides, teachers and homemakers.

Later during the season a program of preventive dental health was taken to all teachers, teacher aides and homemakers in the day care centers. The health education consultant, Dental Health Division, North Carolina State Board of Health, carried out this program, reaching staff members caring for 765 children in the day care centers. This program of dental health education was felt to be extremely important, and plans have been made to expand this joint effort in the future.

IV. TRAINING SCHOOL FOR CREW LEADERS

During the early winter months of 1967, the Farm Placement Division,

North Carolina Employment Security Commission, sponsored two 10-week training sessions for North Carolina home-based crewleaders. These training sessions, financed under the Manpower Development Training Act, were designed to help crewleaders become more aware of the responsibilities involved in their positions and to assist them in increasing their income and their economic security by helping them become more knowledgeable crewleaders. Forty crewleaders who would be responsible for about 1600 North Carolina agricultural workers attended these sessions at the Wilson County Technical Center and the Robeson County unit of the Fayetteville Technical Center. Class sessions were divided between basic educational skills and special sessions with subjects especially pertinent to the crewleader in his job. These special sessions included speakers on highway safety and regulations, automobile mechanics, social security, skills in reforestation (an employment area open to these crews during the winter months) and general sanitation.

Approximately four class hours in each training session were assigned to the Migrant Health Project of the North Carolina State Board of Health to discuss the health promotion activities of their program. It was decided, in planning for these sessions, to emphasize those health promotion activities in which a more knowledgeable crewleader could influence his crew. Therefore the discussions were centered on ways to promote health and to prevent illness and accidental injuries.

Each session began with an introduction by the nurse to the value and importance of a healthy crew to the crewleader and to the grower. Selection

of crew members and regulations that could be enforced by the crewleader in his bus, camp and in the field that would protect the health of the crew were discussed. At this time, information about the functions and services of local health departments was given with the intention of familiarizing the crewleader with the concept of preventive medicine, and encouraging him to make use of the resources of the health department both in his home community and when away from home. The Personal Health Record developed by the United States Public Health Service for agricultural migrant workers was explained and its use encouraged. For those who expressed interest in obtaining these cards for themselves and their crews, plans were to be made with their local health departments to have them available before the start of the season.

Special programs developed for migratory laborers in North Carolina were discussed and illustrated with color slides by the Health Education Consultant with the Migrant Health Project. Family Health Clinics, Day Care Centers, educational programs, clothing stores, and recreational programs were described, and the ways to obtain these services discussed. These special programs were related to the health and safety of the crewleader, his crew and their families.

A film and flip-chart illustrations were used to relate accident prevention to the life of the crewleader. Accidents that can occur on crew buses and trucks due to lack of thought and care were easily recognizable to the crewleaders, and they responded quickly to this part of the program. Ways of coping with the factors that cause vehicle accidents were brought out, along with the responsibility of the crewleader for establishing and enforcing

safety regulations. Home accidents, including poisoning, were reviewed. Accidental injuries and unexpected illnesses that occur during the working day were discussed in relationship to the responsibility of the crewleader. Strong recommendations were made that there be a person familiar with emergency first-aid procedures in each crew. Suggestions from the consultants, the class instructor and the crewleaders were to use a teenager trained in a high school or scouting program, or have at least one member of the crew arrange to take a first aid course during the winter months. The possibility was raised that future crewleader training programs could include a course on first aid procedures.

Building around the Basic Four food groups, the nutrition consultant discussed dietary needs of the normal, working adult. Recognizing the special working conditions of the migrant, she emphasized the low cost, high food value foods, and those foods which could be carried safely to the fields or be prepared quickly without lavish cooking facilities. For those crews who must eat at local stores or lunch counters, nutrition was related to the prepared foods available. Consultation in preparation of low cost, nutritious meals was offered to those crewleaders who provide meals for their crews.

The response of the crewleaders to the presentation by the Migrant Health Project staff and the consultants in Accident Prevention and Nutrition was exciting. The material presented appeared to be of great interest and concern to these crewleaders and the interchange in the sessions was lively and enthusiastic. Because of the great interest shown in the general area of

health by these crewleaders, the Migrant Health Project staff has been assigned a full week in the training sessions planned for 80 crewleaders in the early winter of 1968. In addition to the subjects covered in this year's sessions time will be devoted to discussions on communicable diseases (tuberculosis and venereal disease), alcoholism, first aid and dental health. If possible tours of local health departments will be arranged to increase the crewleaders familiarity with this resource.

As a follow-up to the discussion of Personal Health Records and the encouragement of its use, the health officer or supervising nurse of the home county health department of each crewleader was contacted by telephone and told that these crewleaders had requested information about obtaining Personal Health Records for their crews. When permission had been given by the local health department, the crewleader was contacted by letter and told the days and hours that he and his crew members could apply for Health Records. Each health department was given the names of those crewleaders from the county who could be expected to send his crew in for Health Records. Those counties which did not have a sufficient supply of the records were sent the necessary cards. Each county was asked to do only those tests which they did routinely for health card applicants, and those tests which seemed indicated after interviewing the person. Each county sets its own requirements for health cards, but possible tests included serology, tuberculin skin tests, chest X-rays and immunizations. Responses from the counties varied from reluctant agreement to enthusiasm about the opportunity to establish contact with the crews.

There was no attempt made to ask the counties to keep records of the number of Personal Health Records issued to agricultural workers. Informal reports from several health departments indicated that many of these crewleaders followed through in obtaining Health Records for themselves and their crews.

The contact with the crewleaders attending these training sessions enabled the staff of this project to indirectly reach the 1600 crew members led by these crewleaders, and those people in local communities who are also influenced by these indigenous leaders. The project staff felt that this experience, shared with other agencies interested in the migrant agricultural worker, was a most effective way of improving the general health and living standards of this group.

E. PROVISION OF EDUCATION MATERIALS

The North Carolina State Migrant Project staff conferred with many persons regarding the collection and preparation of education material suitable to use with migrants.

After several conferences three problems were defined as taking priority in and around the migrant camps. They were problems created by poisons, fires and hazardous debris on the camp premises.

Education materials were prepared by the State Project on these three problems and distributed to each local migrant program to be used for educational purposes.

Besides these materials, kits containing samples of education materials on these and other subjects were given to each project director or health department conducting migrant programs. Audio visual aids were suggested that were suitable in areas of educational need. The North Carolina State Board of Health Film Library served as a source to provide films including those prepared for spanish speaking crews.

Following are samples of the materials prepared by the State Board of Health Migrant Project.

TO BE SAFE FROM

POISONS



Do you keep medicines, bleach, kerosene, and bug sprays in a SEPARATE place from your food?

Yes

No

☐
☐

Do you have a HIGH place out of reach of your children to put your medicines, bleach, and kerosene?

☐
☐

Do you always keep kerosene or bleach in the cans and bottles they come in?

☐
☐

Do you call aspirin or any medicine CANDY when you give it to your children?

☐
☐


Do you let your children eat only wild berries that you know are safe?

☐
☐


Do you ALWAYS wash out old medicine and bleach bottles before putting them in the trash?

☐
☐

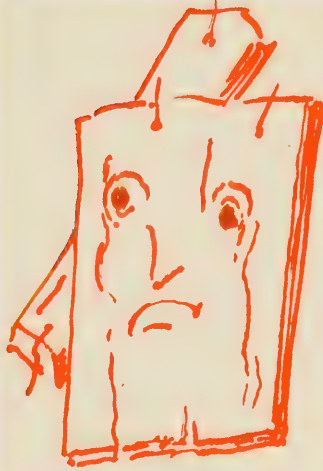

WANTED!

3 ESCAPEES

DANGEROUS TO CHILDREN



MR. BROKEN BOTTLE



MR. RUSTY NAILSINBOARD



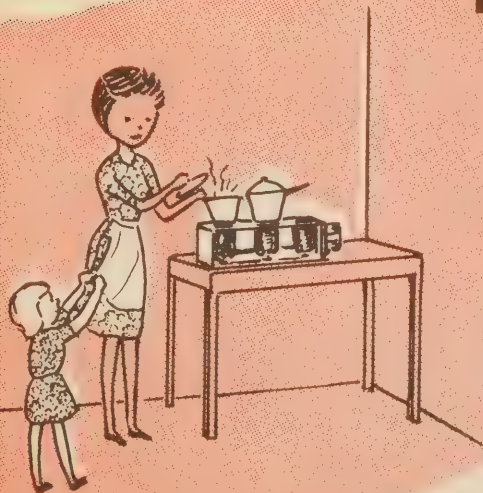
MR. OLDTIN CAN

**PUT THEM
IN THE
CAN!**



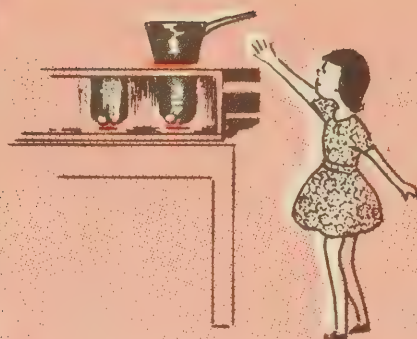
TO BE SAFE

FROM FIRE



Put oil stove against a wall or in a corner out of reach of young children.

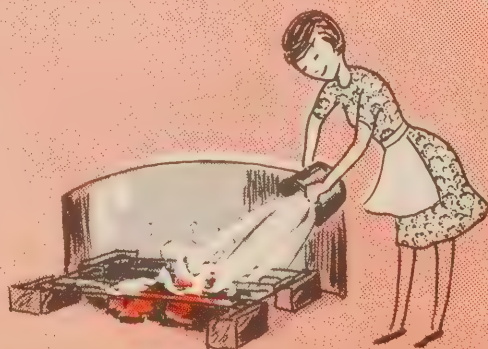
Turn the handles of pots
to the back of the stove.



Stay with an outdoor fire
and keep children a safe
distance from it.



Drown the ashes
and hot coals.



SUMMARY AND EVALUATION

In general, one can state continued success of the State and local migrant health projects. This summary will not try to recapitulate the services and activities that have been described in preceding chapters. Rather, an attempt will be made to discover trends and new dimensions in the migrant labor field, and programs designed to fit these new patterns.

One can say that North Carolina is somewhat atypical of the general pattern. While migratory labor in many areas is decreasing fairly rapidly, this State is maintaining an equilibrium. As automated harvesting increases, there is also an increase in the number of crops, such as fruits, berries, and certain vegetables, that continue to require human labor. It is unlikely, therefore, that North Carolina will see a dramatic decline in either day-haul or migratory labor in the immediate future.

Another pattern that is emerging is the change in the origin of migrants. For many years, migratory agricultural crews came from other states; now, at least half of our crews are home based. Indeed, a number of crews join the east-coast stream and work in other states. We find, then, that North Carolina is becoming a major producer, as well as a consumer, of migratory labor.

For these reasons, it is felt that a new thrust and a new dimension should be considered for future services. Expansion of clinic services

should be carried out by initiating programs where they do not now exist. Further, greater attention should be given to potential migrants in their place of residence, before they go "on the season".

A beginning has already been made. The survey conducted by the State Government Intern afforded some information on both the home-based migrants and their patterns of health behavior. Demonstration family health service clinics were held in Johnston County, a new venture for this county. Further, education was provided in the Employment Security Commission - sponsored crew-leader schools to try and have crew leaders get their crew members to avail themselves of available local resources prior to leaving home.

The North Carolina State Board of Health feels that it is time to provide a new impetus to migrant health services. To augment the existing activities already described, additional funds are requested. This new source of fund, would add one additional staff member to the central agency, and establish new clinic services in selected communities. This is outlined in the budget and budget justification.

In addition, continued effort will be maintained in areas of present activity, and liaison and cooperation will continue between the State Board of Health and other agencies (such as the State Department of Public Welfare and the North Carolina Council of Churches' Migrant Project) who have a similar interest in this field. However, to bring new services to areas of great need, it will be necessary to think of new efforts. Our evaluation of the situation leads us to conclude that this must be effectuated to have an impact on the large number of presently unmet problems.

WORKER QUESTIONNAIRE

Date of Interview _____

Place of Interview _____

Family No. _____

Crew No. _____

1. Demographic data

Name _____

Sex _____ Race _____ State of Birth _____ Date _____

Where do you stay when you are not harvesting crops? _____

How far did you go in school? _____ Did you have any further
training ? No _____ Yes _____

Marital Status: Never married _____ Married _____ Wid. _____ Div. _____ Sep. _____

Family Structure: Who stays with you while you are traveling?
(Ages of children and whether working house-
hold members).

Relation

Age

Working

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who stays with you while you are back home?
Above only _____

Relation

Age

_____	_____
_____	_____
_____	_____
_____	_____

Who keeps your children here while you are working? _____

Who keeps your children that are back home? _____

Does this person keep any other children? No ____ Yes ____

If Yes, how many? _____

2. Work Patterns.

What work do you do when you're not traveling (back home)? Farm Work _____

Unemployed _____ (Source of Income) _____

Which crops do you stay away from home overnight to work?

In North Carolina: tobacco _____ garden crops _____

packing and processing _____ other _____

In other states: garden crops _____ citrus crops _____

packing and processing _____ other _____

When did you first leave home to harvest this year? _____ With
crew only _____

Where did you head first? _____ How long will you be away
from home harvesting crops this year? _____

How many years have you been leaving home harvesting crops? _____

3. Utilization and Knowledge of Health Resources

Home County

Have you ever been to your home county health clinic? Yes ____ No ____

If yes: Why _____

What other help can you get there? _____

If no: Do you know where your county health clinic is back
home? Yes _____ No _____

What kind of help can you get there? _____

The last time you were too sick to work and had to get help back home,
what was the first thing you did? _____

Then? _____

What was the trouble? _____

The last time your children were sick and needed help, what did you do? _____

What was the trouble? _____

This County

Have you ever been to the health clinic here in _____ county?

Yes _____ No _____

If yes: Why _____

What other help can you get there _____

If no: Do you know where the local clinic is here

in _____ county? Yes _____ No _____

What kind of help can you get there? _____

The last time you were so sick while you were on the road harvesting
that you had to get help, what did you do? _____

What was the trouble? _____

The last time your children were sick and needed help while you were on
the road harvesting, what did you do? _____

What was the trouble? _____

What would you do if you needed a doctor in a hurry right now? _____

Do you know where the nearest hospital is? (County of Interview)

No _____ Yes _____

GUIDELINES FOR AGENCIES EMPLOYING
NON_PROFESSIONALLY PREPARED HEALTH EDUCATORS

I. INTRODUCTION

Approximately 6,000 migrant laborers came into North Carolina during the harvest season which begins about May 15 and ends late in October.

In order to help the migrant obtain, as nearly as possible, adequate health services, increase his knowledge of good health practices, provide him with an opportunity to participate voluntarily in his own personal health care and that of his family, North Carolina has four migrant health projects which employ health educators as members of the project staff.

Because professionally trained health educators are not always available for short term employment, some project directors must employ persons who are not professionally qualified in health education to serve as health educators.

This is a guide designed to give guidance to administrators of migrant projects who employ persons to do health education who are not professionally qualified health educators.

II. PERSONNEL POLICIES

- A. Recruitment - The health educator employed by migrant health projects should be recruited and employed by the project administrator or his official representative.
- B. Qualifications - The health educator should be a professionally qualified health educator. However, when professional health educators are not available for this type of short term employment, other persons professionally trained in closely allied fields of health education may be employed. **EXAMPLE:** vocational home economics teachers, community organization specialists, social worker, under graduate health education major.

Other qualifications should include ability and personality required to work with all people of all ages, good judgment, resourcefulness, emotional maturity, good physical health and leadership ability.

This employee would be expected to need little guidance to carry out his functions.

- C. Salary, Work Schedule, Deductions and Leave Policies -

Direction and information as to the above items should be set by the administrator of the project. An explanation of time of day for work should be discussed with the health educator fully. Because of the work schedule of migrant workers, the work hours of the health educator may not be scheduled the same as some other personnel on the project.

- D. Office and Supplies - Office space for the health educator and supplies necessary for carrying out the requirements of his position should be furnished by the local project.

III. STAFF RELATIONSHIPS

- A. Administrator - The administrator will, in cooperation with the health education consultant migrant project, State Board of Health or the district health education consultant, State Board of Health, set policies and procedures necessary for effective work, record keeping and reporting.
- B. Supervisor - Supervision of the health educator should be given by a professionally qualified health educator. If there is not a local health educator available to the staff of the employing agency the administrator may expect the health education consultant with North Carolina State Board of Health Migrant Project to give the guidance necessary. He may also expect help from the district health education consultants from the State Board of Health.

The administrator and the health education consultant should help the health educator to define his function with the project, translate the health education goals of the project into specific activities and work out suggested ways of implementing them.

IV. ORIENTATION AND TRAINING

The Health Educator with a migrant project will be expected to participate in both pre-service and in-service training programs.

These include the pre-service orientation and training provided by the North Carolina State Board of Health Migrant Health Project and the orientation and pre-training given by the employing project. The training provided by the North Carolina State Board of Health Migrant Health Project will be in a workshop setting. Pre-service and in-service training given by the employing agency will be determined by the local staff and the specifics of the role definition will be governed by the project purposes and its health education goals.

VI. SOME SUGGESTED FUNCTIONS OF NON-PROFESSIONALLY TRAINED HEALTH EDUCATORS
WITH MIGRANT PROJECTS

- A. Inform migrants of health services available to them.
- B. Provide leadership in seeing to it that migrant workers understand the correct procedure for getting the available services needed.
- C. Find out what services the migrant workers think they need and help them attain these when possible and feasible.
- D. Teach good health practices to migrant families.
- E. Supervise Health Education Aides
- F. Help make it possible for co-workers and volunteers to learn effective techniques of leading group discussions, making posters, preparing fact sheets and others.
- G. Assist other staff members in understanding migrant health needs.
- H. Identify leadership among the migrant workers and ask them to set examples for other crew members.
- I. Prepare and select health education materials suitable for use in teaching migrant workers about health and good health practices.

- J. Find out some of the barriers to providing adequate health services and facilities to migrant workers and plan ways, in consultation with others when necessary, to alleviate them. EXAMPLE: inconvenience in clinic procedure, time lags, transportation needs and housing facilities.
- K. Promote recreational activities by making equipment available, scheduling time and place, and when possible, securing professional help from other agencies to help plan and carry out recreational activities.
- L. Integrate the migrant into the community life as much as possible-
EXAMPLE: Churches Stores and shopping advantages
Schools Health and welfare services
- M. Be able to explain goals of the project when necessary.
- N. Provide leadership in the development of the educational aspects of the agency's programs.
1. Establish health education objectives for specific activities. EXAMPLE: plan meetings with a specific purpose that relates to project goals.
 2. Design, prepare and use visual aids such as flip charts, flannel boards, exhibits and filmstrips as teaching aids.
 3. Use appropriate audio-visual equipment such as motion picture projectors, slide and filmstrip projectors, overhead projectors, tape recorders, etc.
 4. Prepare materials, such as news releases, radio and television spot announcements, scripts, leaflets, brochures and make speeches.

O. Provide leadership in the development of community centered health education programs.

1. Work with other agencies in the community which are concerned with the development of migrant health programs.

2. Inform community leaders about health problems and programs and encourage their participation (e.g. organize neighborhood or club meetings, speak before groups.) EXAMPLE: groups of growers, crewleaders, county commissioners, other health and welfare workers, church groups and school groups.

P. Identify health problems among migrants requiring additional study and research such as: housing - garbage and sewage disposal - clinic schedules, types and services and call to the attention of the staff.

Q. Report and publish adequate and up-to-date reports.

GUIDELINES FOR THE COORDINATOR
MIGRANT HEALTH PROJECTS

Project Director

A. In order for the coordinator to carry out his duties it will be necessary for the project director to make available to him the following materials before the coordinator assumes his duties.

1. A complete copy of the project application including the budget and the objectives.
2. A reporting kit containing instructions for the annual report and blanks for financial reports and for project renewals or continuations.
3. Copies of the annual reports from the preceeding years.
4. Copies of all correspondence relating to the present migrant project when and as received.

b. Well in advance of the season, the project director will have a meeting with the treasurer and co-ordinator to discuss the budget and bookkeeping requirements (number of copies of bills, signatures, dates, timing, etc.), reports and project application.

Co-ordinator

A. The co-ordinator will, according to Webster's definition, lead the staff "to act together in a smooth concerted way" to achieve the objectives

of the project. To do this he must maintain an office and be in that office during regularly scheduled hours. He is to delegate duties and to secure competent services for the project.

1. In order to achieve this concerted action he should assist in securing an adequate staff and acquainting them with the project objectives before the season begins. Pre-season training of the staff should be planned in order for the staff to know what their duties and responsibilities are for meeting the objectives as outlined in the project.
2. One of the main tasks of the co-ordinator will be acting as a public relations official to strengthen public approval and acceptance of the program. One of his first tasks will be to establish working relationship with other community agencies, both voluntary and official.
3. Before the season begins, the co-ordinator will, with direction from the nurse and doctor, buy the necessary basic supplies for the clinics. This will allow quantity buying and will reduce to a minimum day to day purchase.
4. A schedule for regularly planned staff conferences that include the director and representatives from home makers and/or case workers and/or welfare department, day care centers, health department, Employment Security Commission, farm extension, growers, and schools should be made so that coordinated planning

can be achieved. Any other agency working directly or indirectly with the Migrant should be invited to send a representative to the staff conferences. This does not preclude other conferences of only the official migrant project staff for in-service training or to discuss matters applicable to them alone.

5. He will supervise the procuring, preparation and maintenance of equipment. The maintenance and repair work should be done by qualified persons under a contract or agreement.
6. The co-ordinator will establish liaison with the local hospitals so that the hospital staff will understand the project's responsibilities and limitations in regard to the migrant requiring hospital care.
7. Requests to the project staff for emergency transportation will be cleared through the co-ordinator's office. He will evaluate the request and secure appropriate transportation.
8. He will keep records, make reports and, with the assistance of the project staff, coordinate the writing of the annual report.

In cooperation with the treasurer he will assist the director in making the application for funds for the following year.

9. The coordinator will become familiar with the resource personnel, local, state, and national, and the services they can offer, and seek their assistance and advice when appropriate.
10. He will, with other agencies and organizations providing services to the migrants, work to provide a well planned coordinated program so as to eliminate over-lapping services. He will not, however, assume supervisory responsibility for said agencies or their personnel.

BARRIERS TO EFFECTIVE UNDERSTANDING

By Sam Schulman*

In working with migrant families the health community--as well as teachers, ministers, labor union representative, welfare workers: in all, members of the "helping" disciplines--have encountered problems. If there were no problems there would be little need to invest time, personnel, and expenses involved in conferences and institutes dedicated to trying to resolve some of them. Many of these, our problems, revolve around a common rubric: "lack of effective understanding." The misunderstanding is generally a two-way proposition: they (the migrants) do not understand us, and (the helpers) do not understand them. It is certainly evident that there are cases, involving some of all of us, some of the time, that this situation does not obtain: there are, indeed, episodes of true harmony. But it is not the general rule. The fact that misunderstanding rather than understanding is encountered disturbingly often explains our presence here. What is of significance to us is that we know that misunderstanding is a prelude to poor, ineffective, or

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non-enduring human interrelationships.

In an hypothetical ideal sense, there are two (or possibly more) identifiable entities in the process of misunderstanding: the "we" and the "they" components. Our analytical approach then shall be concentrated in an evaluation of the "we" and the "they" and the situation, or context, that brings them together in a manner that demands their working together. The questions of concern, then, are: "Who are we?", "Who are they?", "What are the dynamics of our common contact?", "How can we resolve, remedy, or ameliorate the misunderstanding that exists between us and, consequently, our interrelationships?" To these questions I shall address this paper.

Who are we?

At first glance this may appear a superfluous, if not an inane, question. We supposedly know who we are. But oftentimes we don't really. Each one of us is the encumbent of many parts, or roles: we wear many hats. The hat we wear on one occasion may be alien, exotic, if not downright ridiculous in another. Let us use a case in point: the warm physical mass of sap and sinew that is my person.

To those at this meeting I am a consultant to the Migrant Health Branch of the Public Health Service. To several hundred young men and women back in Fort Collins, Colorado, I am a professor. To my professional colleagues I am a sociologist. To more limited groups within the sociological community I am a "medical" sociologist, a specialist in "development" or in "Latin America." To my banker I am "of the middle-income group." To my old college chums I am "that passing fair pinochle player" or "one of those singers of sad

non-enduring human interrelationships.

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songs." To my children I am "Daddy." And to my wife I am "the old sour puss." And I could go on, for there are many hats that I wear. Each one of us wears many hats. Each one of us enacts many social roles, and the composite of these roles is our social person. We must compartmentalize these roles: we usually don't get them mixed up. Yet, we must realize that they all exist and are part of us.

Herein, perhaps, lies the seed of our first major problem. Some of the things we are we cannot but carry over into a situation that really calls for the enactment of a single dominant role. As an example: a teacher of a group of migrant children in the third grade. She is entrusted with this task of the education of fifty children, early in May, children who have been taken from other schools in other places so that their families may make a living by following the crops. So, here is our teacher: white, around twenty-three, a university graduate, Protestant, highly motivated. She shall have these children as her wards for only a few weeks. Her presumed level of instruction is the third grade, but she finds that most of her children can barely write their names and cannot read, even minimally well, without her assistance. Her basic role - that of teacher - is difficult enough. But she finds that she cannot compartmentalize herself in this single difficult role. She feels that she wants her students to be clean, for few of them are "clean" as she understands the word. Most have skin infections and, on their hands and faces, blots of infection are caked over with accumulated dirt. She wants them to brush their teeth. She wants them to sit properly so that their spines will not be bent. She wants them to go to church and learn some moral principles, and internalize them, for she has seen them at play, and some of

that is sheer sexual game-playing, especially among the older children. Need we go on? Need we say that our little "Miss Third Grade Teacher" is involved in a situation in which she is much more than "teacher," and that she will wear many hats during the course of the day, sometimes several hats at the same time, none fitting too well.

We bring to any interactive situation, first of all, ourselves. And who are we? It would be to reduce to an absurdity a definition of ourselves that included every common denominator we possess: they would be few and quite meaningless for us to use them as a basis of action. If all of us were women, or Roman Catholics, or left-handed; any of these would provide us with a list in our collective minds of things we would (or could) do and another list of things we wouldn't (or couldn't) do. We are, however, a collectivity with certain common denominators that can provide us with an overall picture of ourselves, which most of the time would fit most of us.

We are generally white which, regardless of social legislation and Supreme Court verdicts, still has sociological significance in the Southeastern part of the United States. We are motivated to work for or with migrant laborers. In this part of the country it would not be remiss to state that we are mostly Protestants, and mostly Protestants of fairly conservative persuasion. Most of us who work with migrants would be classified as professionals or sub-professionals, typically university graduates or those who have had special training which would be the equivalent of university education. Most of us would identify ourselves, and would be identified by others, as members of that difficult stratum of American life we call "the middle class." Many of those present have a rural or semi-rural background

and think that Chicago, and New York, or even Raleigh would be "nice places to visit" but "we wouldn't want to be from" there. We all, most significantly, want to break down barriers to effective communication with another collectivity -- the migrants.

The Migrants: Who are they?

It has been a necessity throughout the United States that rural production of any kind is linked to such ubiquitous conditions as general climate, topography, amount of rainfall and when it falls, soil types, availability of machine and hand labor. Some crops, such as the grains, require very little hand labor and depend greatly on machines for plowing, planting, weeding, tendering, and harvesting. Other crops must depend more on hand labor, and yet other crops--such as most of our truck crops, fruits, and berries--need the special sensitivity of human minds and human hands a great deal of the time. On the other hand, some of these latter crops need this human mental-tactile facility only at certain times. One such time is "harvest." A fairly large number of human helpers must be available, and at a specific time, or certain crops cannot be harvested. In a nutshell, this demands a corps of workers who are available at peak harvest in various parts of the country and at various times during the year. Herein lies the genesis of the migratory streams: crops of available farm helpers who move with crops. It may seem impossible, but the tomatoes of Northern Ohio and the cherries of central Michigan would, in large measure, rot on the vines and trees if some farm laborers did not move there for a few weeks or months from the deepest parts of Texas. Seasonal farm work requires seasonal farm laborers. We no longer produce wheat, berries, apricots, and asparagus just for home use. Our peak seasonal

gathering of such products makes it possible for there to be fresh strawberry pies in Anchorage, Alaska; apricot preserves may be marketed in Indio, California; fresh asparagus covered in a cream sauce are served at expensive restaurants in New York; and Kansas wheat makes for part of your bread everywhere in the United States and in countless countries beyond our borders.

The key to seasonal farming is the migrant worker. But who is he? He is someone who must leave his home and follow the crops. But this, alone, is another meaningless common denominator. Let us take a closer look. He is, first of all, poor. He is poor in his home community and would be poorer if he stayed there. He takes his poverty on the road so that it would not be even greater than it is. About a million migrants, workers and their families, make the trek south to north, every year. They begin typically in the deep South (and these are mostly Negroes), or in the border areas of Texas and Mexico (and these are mostly Spanish-speaking). For many years West Indians were imported for work in the Florida cane-fields, and Mexican nationals - braceros - followed a two-pronged stream through the Middle West and into California, Oregon, and Washington. Most foreign contracted seasonal labor has now considerably diminished, and American citizens (or resident aliens) have continued the streams.

Here, in North Carolina, the migrant is chiefly Negro, but he is still a poverty-stricken Negro. A smaller number of whites and Puerto Ricans also share this movable poverty.

Poverty is a way of life, one forced upon its victims, one from which the Negro has little or no opportunity to escape. Even where he has made

the "permanent" move from the South to a Northern city, he is thrown into the ranks of those competing for menial jobs, and finds his new "home" in the Negro ghettos of these cities. The Southern Negro farm laborer who becomes a migrant takes his "culture of poverty" with him. It is a rude thing. It permits for laxity in even a minimally demanding moral code. He spends a greater share of his income than he can afford for hard drink, and is often in debt to those like himself. His family lives on a fat-heavy, protein-light diet, and his children drink more Coca-Cola than milk. His religion is of the deeply evangelical variety with semi-literate preachers pounding simple images and concepts from a Bible he and they can barely understand. He is not just a Baptist or Methodist, but a "shouting" Baptist or Methodist. The migrant's work week may be punctuated by bouts of hard revelry. He is the Negro poor, and besides, he is the rootless Negro poor. He has little knowledge or experience with "community life," because he has been excluded from, and excludes himself, from the community. His women bear large numbers of children, most of whom suffer from some type of sickness--impetigo, diarrheas, undernourishment. Little, typically is done to alleviate these conditions. To the migrant mother, they may be considered "normal."

The dynamics of contact.

Let us make one thing quite certain. Those of us interested in the well being of the migrant and his family, have initiated and sustained most contacts with them. Certainly, there are migrant mothers who attend well-child clinics regularly, but it was "introduced" to them directly or indirectly by us. We have sought our contacts with them; perhaps we have imposed our contacts

upon them. A migrant minister does not hang out a shingle in a camp stating "James Smith, Minister to Migrants." Reverend Smith goes out of his way to seek out troubled souls. Nor, to begin with, did Sally Jones, P.H.N., set up clinic-keeping in a migrant camp and wait patiently for patients to walk in. Nurse Jones had to beat the bushes for clients. Public welfare workers, physicians, teachers--the lot of us--have sought out the migrant and his family, chiefly because of our desire to help. How does the primitively religious migrant woman realize the God is her Father as well as the Father of the "higher ups", and does his Fatherliness mean the same to her as to Reverend Smith? How well does she understand the often complex germ theory of disease as Nurse Jones explains the benefits of a D.P.T. inoculation for her baby? What good does the migrant family see in school for their children when they cannot reap its immediate benefits, nor can they see any long-time life-chances for their semi-literate children.

The situation of contact between migrant families and members of the helping professions is one that is essentially artificial. By the rules of social conduct, we would not usually seek out migrants as our friends, nor would they seek our company. Through the authority granted to us by the law, or the clamoring of our own consciences, do we initiate and maintain these contacts. We, representing the greater community, do not wish all to be threatened with a diphtheria epidemic that may break out in a migrant camp. We, of the greater community, recognize that our laws are a sacred heritage, and we do not wish them to be challenged by these necessary transient lodgers in our community. While the migrants are in these communities of ours, they are not our guests: they are with us, not of us. They are necessary sojourners.

We take no pride in them, nor they in us. Situations of contact with migrants and members of the helping professions are situations of convenience--our convenience.

Why do we misunderstand one another?

The question we ask at this time is, perhaps, not really needed. From the foregoing it is obvious that misunderstanding takes place. It is almost inevitable.

Many years ago the social psychologist Kurt Lewin noted that each of us lives in what he diagrammed as a "life space." Each of our life spaces may be congruent with that of others, and it is on this basis that we can form associations, friendships, mergers, marriages, and the like. On the following page is a generalized diagram of the group life space of the migrant, chiefly the Negro migrant, and of the white members of the helping professions. Note that in this model the area of congruence between the "we's" and the "they's" is a bare overlap in the area of economic activities. Diagrammatically this is the only area where our conceptions, preconceptions, norms of behavior, value systems, and behaviors coincide. "We" know what to expect of them, they of "us". It is understood that, as an example, a worker must pick a certain number of a crop to be paid a certain amount of wages. A migrant will not pick more for this amount, and his employer will pay him no less than the agreed amount. It is also understood--in the non-economic sphere--that the paymaster should be addressed as "mister" , even if the "mister" is followed by a given name, and that the worker should be addressed by his given name directly, his surname directly, or even as "boy" (even though he is fifty years old). These illustrations, as well as many others, are

"acceptable" because they fall within the area of congruence, and this area is not large. There is, on the other hand, much incongruence.

Let us take the example of patterns of child-rearing. The typical white middle-class child is a "wanted" child and, in general, is planned for. (Of course, I know there are "accidents." To the best of my knowledge, I was an "accident" late in the child-bearing history of my mother.) Professional middle-class people, even those whose religion may proscribe the use of mechanical contraception, try to plan their families. It is not unusual for us to hear of how children are "spaced" so that all are not in college or in the armed services at the same time--and this while the children are still toddlers or, in some cases, even before they are born. Consider now, the attitudes regarding having children of the poverty-ridden, generally ignorant and poorly educated Negro migrant family. A child is almost always welcomed, but he is typically not planned for. He may, in fact, be the product of a rather casual union. The white middle-class child is carefully nurtured--the baby foods, the special formulae, the medical check-ups, the concern for proper growth and weight gain, the "Dr. Spock" baby. The child of the poor Negro family grows as he can: there are few special formulas, few baby foods, and only a rare "Dr. Spock" baby. He grows as he can, toddles and plays with many less "no-no's" than his middle-class white counterpart. I do not wish to perpetuate the myth of the fatherless Negro home, but it is certainly true that a Negro farmhand who works from pre-dawn to sundown has little time to play with and fondle his child and, when relaxing time comes, he prefers adult company to his baby. This does not mean that he is a bad father; he is a father who fulfills the expectations of his role within the

poor Negro family.

In each phase or discussion of the life space of the white middle-class and the Negro lower-class we find major, if not radical, differences. This would be the case if we were to compare our lifeways with those of any poverty-ridden people; the Puerto Ricans, the Spanish-speaking migrants, what-have-you.

How to remedy or ameliorate misunderstanding?

A rather simple statement, so simple that its ease of statement may easily confound the intensity of its meaning, gives us the guidelines to the amelioration of problems. "Problems" may run the gamut of the threat of a total war of annihilation to a rather mild dispute over some minor incident in the relationships between husband and wife. Our basic problem is "How do we overcome the lack of effective interaction between migrants and those who seek to help them?"

The simple rule is this: If two or more parties are in discord, disagreement, dissension, conflict, and the like, better relationships can be achieved if: A) there is greater knowledge of the two or more points-of-view involved, and B) that there is sufficient motivation to end or mitigate the discord in a mutually satisfactory manner.

We began our discussion with the fact that we face barriers in effective interaction between us (the helpers) and them (the migrants). For many reasons it is best to assume that of the two groups that of "the helpers" is more flexible in its attitudes and in its behaviors. I am saying that we should be the first to move to dissolve or minimize the barriers. Because

of our superior education, our better life chances, our desire to help, we should expand our already established high motivation, and make more profound our knowledge. The high motivation, indeed, we have, or we would not be here. But our ignorance of the people we seek to serve is profound. We must, then, make more effort in understanding the lifeways of the migrant. Intellectually we must stand in his shoes and see through his eyes.

If what we see is in sharp contradistinction to what we believe to be correct, or beautiful, or approvable, let us remember that we are not standing in our shoes, but theirs. We must, as the psychologists would tell us, sublimate our own manners of thinking, of sensing, of acting. This is to understand.

But we are interested in change as well as in understanding. We want these people to have a better life than they have: we want them healthier; we want them to better their children's intellectual potential; we want to see them as contributing members of our total society. In this regard, knowing them better allows us to look for the "loopholes" in the way they see life, wherein we might enter. Let us assume, for the moment, that we are all "Madison Avenue types," and we have a product to offer the average housewife--say, a new detergent. (We know, of course, that our detergent is really not any better than twenty other brands already on the market.) First, we study intensively the purchasing habits of the housewife-shopper, especially as regards detergents. Then, we plan an idea-influencing campaign (in the armed services this used to be called psychological warfare). We find that women like single-word names, and that they like these words to be descriptive of something they find pleasing or exciting. So we try

several names for our product: "Smooth," "Velvet," "Soft," or, on the other hand, "Double White," "Zing," "Flash," and "Explode!" We find, again by painstaking analysis, that "Flash" is a good name. We know that other detergents have added bluing power or bleach in little crystals of blue or green. We then choose red - something different - to do the same thing. "The little red dots of "Flash" "give you the whitest and the brightest underwear in the neighborhood!" Need we go on?

Let us return, for a moment, to our diagrams of the life spaces of the typical white, middle-class "Helper" and the typical Negro, poverty-ridden migrant.

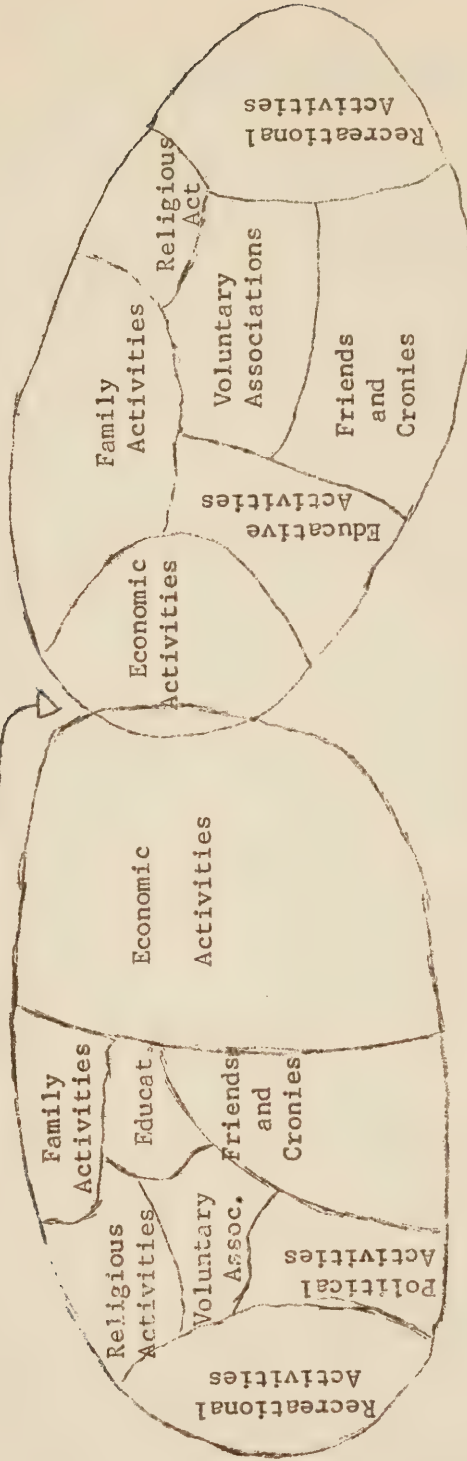
If, indeed, we are seeking to terminate all possible discord between the two, we would seek to bring about greater and greater areas of congruence. But we are not seeking to assimilate one life into the other: This would certainly eliminate culturally-based discord, since all would be not only congruent, but the same. This is far from our goal. We wish to broaden the present area of congruence and, if possible, find other areas of congruence with the expressed idea of making life better for the migrant worker. We wish to maintain the identities of the two life spaces but, where possible, to bring them closer together. In effect, we would like to try to change the internal structure of the life space to look more like our life space, to find greater areas of congruence between them, yet for each to maintain its own identity. A first, and most important step, in this direction is looking at the migrant's life space with greater profundity than we usually have. The "loopholes" we seek cannot be seen unless we examine the entire structure of his life. We must all, in our own ways, be "Madison Avenue types" in selling

good health, good moral attitudes, good citizenship.

Through our understanding of migrant culture, of the migrant's way of seeing things, we can find the "loopholes". What are the "loopholes" that can lead to cleanliness, preventive medicine, a greater commitment to religion, a greater effort to improve children's education, a greater understanding of birth control, a better use of public and private agencies available to them for their own betterment. This is our chore: to find better ways of serving our people--for they are our people--and to do this as efficiently as we can. And when we look for resources upon which we may depend, we find that our first, and best, and most willing resources are ourselves.

The life space of members of
the "helping professions"

(Area of congruence)



The life space of the
Migrants

Migrants Are People*

by

Thomas E. Roberson**

Needless to say, I spent many restless hours over the assigned subject--"Migrants are People"--not because of the subject itself, but rather in trying to decide what I could say to a group like yourselves--people who truly realize that migrants are people. You have long since demonstrated this fact by the manner in which you have been serving these workers through your various projects and programs, as well as by the nature and kinds of State-wide Conferences you have held during the past three years. Furthermore, the very theme of this year's conference--"Barriers to Effective Understanding"--suggests that it is people of whom you wish to develop a better understanding. Therefore, to try to sell you on a concept, or to try to convince you, even, that migrants are people, would be extremely presumptuous on my part.

Instead, I propose to share with you some of my feelings and beliefs regarding the subject, about the extent to which migratory agricultural workers may or may not perceive themselves truly as people, and then to have us think together about the challenge that still awaits us as we continue to work with this population group. In so doing, I propose to draw heavily upon my family background and early childhood experiences, and do hereby beg your forgiveness, lest somewhere along the line I may be misunderstood because of

*Presented at the 3rd Annual Conference on Migrant Health, April 28, 1967, Camp Betsy-Jeff Penn, Reidsville, North Carolina

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some of the things I am about to say.

Fifty-eight years ago on the 9th of this month, I was born in the hills of Mississippi, exactly 10 miles south of the "dream house" of the late Senator Theodore G. Bilbo. I was born and reared in a very isolated community, to be sure; a community which in many ways, except for its lack of mobility, was very much like unto situations in which migrant workers often find themselves today.

I was born unto a parentage of low educational and economical status, but rich in pride and basic principles of life and living. For example, my father claimed to have finished fourth grade. I say "claimed to have finished" only because during the 22 years of my experience with him before he died in 1930, I had no real evidence which would indicate that he did. During that time I did see him on several different occasions sign his name. I never once saw him write a letter, read a book, or read the newspaper, even.

Despite his limited formal education, my father was a hard worker and was looked upon by others in the community as being a "good man." And he was a good man; he was a family man who always provided for his family to the best of his ability and within the limits of his almost non-existent financial resources. Also, he had certain basic principles he lived by. One which he always preached to us was,

"He who eats bread that he himself did not earn is a thief."-- meaning, "I don't want ever to hear tell of any one of you begging or stealing. If you need something, or want it even, always ask your mother or me. Understand!" Another, "Don't sit around expecting something for nothing"--meaning, "to get something you really want, you must always be prepared to work for it."

Consequently, when I reached the age of 9, and as soon as our 5-month school year was over, I was found working at a slab chain leading to the fire pit of a sawmill for 75¢ a day, with my brother who was then 11 years old working along side me for \$1.00 a day. This means that for seven months out of each year my brother and I were gainfully employed and contributing substantially to our own support and to the support of the family.

Exactly how my father felt about education, or the significance he attached to it was not known by us. Being a man of few words, he seldom verbalized his feelings to anyone. When my brother, at the age of 16 and in the 7th grade, asked my father if he could stop school to work for three weeks just before Christmas in order to buy himself a suit and a new pair of shoes, he simple replied, "Okey with me, if that's what you want to do."

In retrospect, I do recall two different occasions, perhaps, when he probably did give some indication of his feelings in this regard: The first time was the neigh I graduated from 8th grade. Having always worked at night as far back as I can remember, my father not only took time off from work that night long enough to attend

graduation, but sat in the front row of seats during the entire exercise. The second time was after I had finished ninth grade--the highest grade taught in the last school I had been attending. About the middle of August of that year, I arrived at home from work at the sawmill just before he left to go to work. I gathered up enough courage to speak with him about my future plans regarding an education. Seated in a swing on the front porch, I approached him with the idea of my going away to school, and at the same time assured him that I would seek employment to the extent that I would be able to "work my way" through--that is, through the remainder of my three years of high school and four years of college (And I did.) He simply glanced at me out of the corner of one eye and said, "It's up to you." But two afternoons later, I happened to be standing nearby as he was leaving for work when I overheard him saying to my mother, "You know, Bella, I think that boy wants to be something, and we've got to help him."

Yes, these are the only times I can recall that he ever gave any indication as to how he felt about the importance of education, and needless to say, this really meant something to me--even now. Certainly, he was neither encouraging nor discouraging about education. Rather, he always seemed neutral.

On the other hand, however, and as I tried to indicate earlier, he felt that it was his responsibility as a husband and as a father to see to it that his family never suffered from the lack of certain basic necessities--food, clothing, and some form of shelter.

Beyond that, due to his very limited resources, he could promise nothing.

And now just a word or two about my mother who claimed to have finished 6th grade. She was quite a different personality, to be sure. In addition to being a warm, cordial, outgoing woman with an odd sense of humor, she did all the reading and writing for the family; that is, until we were able to do so. She had a terrific memory and thoroughly enjoyed reading, almost always keeping abreast of current events.

Not only was she interested in education, but she also had specific goals for each of her four children which she so very much hoped we could attain. As for my oldest sister, she wanted her to be a teacher. As for my brother who is $1\frac{1}{2}$ years older than I, she wanted him to become a doctor. For some reason, she wanted me to be a pharmacist. And as for my youngest sister, she wanted her to be a nurse.

Well, let see what happened. My oldest sister who was to have been a teacher was married at the age of 16 and later came to be known as one of the best seamstresses in the southeastern part of the State. In 1945, she opened up her own business and began specializing in the handtailoring of men's clothing--sport shirts and slacks, sport coats, and suits.

After being discharged from the Army at the age of 38, my brother who was to have been a doctor enrolled in an accelerated program of education for adults and finally completed high school and one year of college work. Almost two years ago now, he became self-employed.

My youngest sister who was to have been a nurse completed college and is now doing work toward a Master's degree. In addition to operating a small business of her own, she is teaching in one of the elementary schools of the Jackson (Mississippi) public school system.

As for the one who was to have been a pharmacist, well here I am. While neither of us attained the goal she had set for us. I somehow had the feeling before the time of her death almost 9 years ago, my mother was not too unhappy with the results of her efforts.

In what kind of a community setting did we grow up? Until I reached the age of 12, we always lived and grew up in the one sawmill community--a sawmill camp to be sure. It was a very small community, but one which had the three basic institutions--church, school, and home--to be found in most communities.

Perhaps one of the unique features of this little community was the close working relationships which always existed among these three basic institutions. For example, our minister who visited the community once a month, was an extremely warm and cordial man, and perhaps, the most effective family counselor I have ever known. In addition to his monthly sermon, this minister always remained in

the community long enough to visit the sick and the needy. In many ways, he was almost an idol for the community.

As for our school, classes were always taught in the community church. Here, running water, health services, handwashing and toilet facilities and the like were non-existent. In this one-teacher type school, the grades taught ranged from the primer through 6th grade, with our teacher having only finished the 8th grade. School opened each morning with a short period of devotion and closed each afternoon with either a Bible verse or a prayer. Friday afternoon of each week was always the day parents were invited and expected to visit the school. And we could almost always count on a visit by our pastor every fourth Friday of each month.

Our only teacher, realizing full well that she was responsible for the entire operation of the school, instituted a rather interesting practice within this school. She assumed full responsibility for teaching the children enrolled in the primer and the 6th grade, while (under her surveillance and supervision) the brighter children of the second grade taught the first grade; those of the 4th grade taught the 3rd grade and so on.

As for the community itself, the homes as well as family and community living were very similar to what one would find in many camp-like situations. But somehow, in this little community with all of its draw-backs and limitations, something often happened.

In it there seemed to be something that was often challenging-- not just to our family but to some other families as well. What I have said about our family, I can also say for a few others. That setting, as limited as it was in so many respects, occasionally seemed to engender within some of us a feeling of confidence and a real sense of value and worth, as well as a desire to move ahead.

Specifically, what it was and where it came from I don't know. Sometimes I wonder, however, how much the little stories and poems we were required to learn and recite at day school, sunday school, and at home may have contributed to this kind of stimulation. Particularly, do I recall a poem which all children without exception had to learn and be able to recite by the time they completed sixth grade. The title of this little poem was "I Believe in Me" and it read something like this,

I Believe in Me

There are numerous creeds, to meet everyone's needs
That I meet along my way;
Some I accept, or maybe reject,
I may not believe, or I may.
But whatever I do, just between me and you,
To be happy, successful and free,
Here is all that I need, just this one short creed,
"I Believe, I Believe in Me."

To have confidence in yourself is immense; a feeling of "I know I can"
Puts a spring in your step, gives you an abundance of pep,
It makes a difference, just ask any man;
For without this belief, your attack will be brief,
You will fail where you ought to succeed.
So to make for success, and you wish for no less,
Believe in this short little creed.

If you think you will fail, that's the end of the trail,
For as you think in your heart, so are you.
If you think you'll succeed, that's all you will need,
If you follow your plans right through.
Belief, that's the thing, as you work you can sing,
For you're confident and that's how to be.
You'll be happy and bright, in your work you'll delight,
When you can say, "I Believe in Me."

Take a mirror some day, look right in it and say,
"Size up the man which you see."
Do you think I can win? If he nods, with a grin,
Then he's with you, and successful you'll be;
But if he drops his eyes, and just kinds of sighs,
Then you're licked, for with him you've agreed.
For the man in this case, whom you looked in the face,
Can cause you to fail or succeed.

But when the man in the mirror, who gazes at you,
Is with you one hundred percent,
There isn't a thing you can't go and do,
Beneath the entire firmament.
So talk with, plead with him and, if need be, without delay,
So he'll be what you want him to be,
And then when you look in his eyes, you can say,
"Thank God, I Believe in Me."

Yes, I am not at all sure but if what it were not these kinds of things in such a community setting that helped to engender this feeling of confidence and a sense of value and worth, thereby resulting in some of its members truly seeing and feeling themselves to be people in the context of the philosophy of this conference. What, then, are the implications here for the different agencies in the many different communities in which these workers find themselves each year as they help to meet so many of their physical needs?

So as we consider the subject further in relation to the theme of our conference--Barriers to Effective Understanding--I wholeheartedly agree with you that we must keep in mind that we are dealing in a highly complex area which involves perceptions, feelings, and

judgments--not only those of our own--but the perceptions, feelings, and judgments of those of whom we speak. For how they feel deep down inside is what matters most. What their past experiences have been and how they have been affected by them not only makes a difference in how they perceive themselves now, but more than likely have affected any dreams, aspirations, and hopes they may have had for themselves and their families in the future.

In the interest of time, let's review together briefly just two other factors which I feel can make a real difference in how, not just migrants, but people in general may perceive themselves. The first of these is one's socio-economic status.

As you so well know--certainly much, much better than I--migratory agricultural workers as a group are highly mobile people, and except for harvesting the crops, they have very few or no other employable skills. Consequently, they become lonely wanderers, roaming from place to place in search of work to satisfy sheer basic human needs. Repeatedly, studies have shown that because of this high rate of mobility and due to a lack of financial capability, they are automatically relegated by communities in almost every situation in which they find themselves to the lowest of socio-economic status. Moreover, they are looked upon and often referred to by these communities as the vagrants--those shiftless, thickwitted, and outright dirty, lazy, migrants; those tumbleweeds, Joads, winolas, and bums from Foggy Botton and Skid Row.

Yes, in too many of our communities, even today, they are too often seen and judged only in terms of this low status without realizing that they are often migrants because they are of low socio-economic status.

Again, as studies have show, low status people in most communities, whether they migrate or not, usually suffer from the deficiencies and disadvantages of those communities, i.e., poverty, poor health, ignorance, limited vocational skills, low employment potentials, humiliations, depressions, and many others; also that such handicaps, however debilitating in their effect, are aggravated all the more so by mobility and this lack of capability.

To be placed in situations such as these each time one enters a different community, and several times during a single year, must be rather traumatic indeed. What then, is likely to be one's reaction to such situations and how is one likely to perceive himself in them? I don't know, really. I simple raise the question.

The second of these factors is the lack of community acceptance and problems of adjustment. Obviously, each of these is closely linked to low socio-economic status. And, again as you so well know, persons occupying low socio-economic status in almost any community do so as a rule as members of a particular class or "caste" so to speak. They usually live and function as a segment of that community, having been set apart from the rest of society,

stigmatized, and controlled by rigid barriers of law and practice.

Studies have long since revealed that class or "caste" membership in a community usually represents low status, mainly because persons making up that particular membership are often barred from most of the opportunities that community offers its other members. Consequently, such persons tend to move around in a circle whose touch points are poverty, deficiency, inferiority, and non-opportunity, to say nothing of disillusionment and despair. More often than not, the end result is self-isolation where members of that class or "caste" have no other alternative than to turn to other members of their own group for the larger part of their social contact. Here they tend to cling to older values, older views, and older ways of doing things.

In far too many of the situations in which they find themselves, migratory agricultural workers are rejected by the community without acknowledging or fully appreciating, even, the real contributions which these workers make each year to its total well-being.

Far too often, residents of such communities are disinterested in their problems and needs, simply seeing them as outsiders who will soon go away. And far too often, while working in a particular community, these workers are placed under close police supervision and barred from most public and private facilities.

Needless to say, experiences and situations such as these often rob them of any self-respect, confidence, and dignity they once had. As one of these workers once expressed it "I think living and working as we do, one grows the feeling that other folk look down on us as outcasts. They give one that don't care feeling."

So here in their ever changing surroundings--so aptly described as being frequently hostile and rarely friendly--the forces of a depressed life often rise out of each day's new insecurity only to keep alive in many of these workers fear, anxiety, apathy, hostility, and sometimes hate. And even if their older ways do not satisfy or protect, they are at least known and, therefore, clung to all the more fiercely by them. As a result, the barriers between many of the workers and these communities rise higher and higher each year, and disillusionment, bitterness, and withdrawn resignation swell in them to the point that their children even are often lost to them and to society. So as you can see, under conditions such as these, migrancy for so many of these workers is but another hurdle in the long hard struggle for survival.

To be sure, congratulations are in order to you and to the other 90 or more migrant health projects scattered throughout the country that are so ably meeting the physical health needs of these workers. Just as you do, I too believe in first things first and would be among the first to agree that meeting the physical health needs of these workers is an important, perhaps the most important

perhaps the most important, first step. Also, I wholeheartedly agree with you when you say that migrancy among these workers often is a symptom of something much more basic, and to limit our efforts to the health aspects of mobility alone, as though it were the single or primary causal factor, is to overlook other conditions which, in fact, may have led to it.

As the theme of this conference so aptly implies, it is these other factors which we must now begin looking into for the kinds of understandings that will enable us to deal most effectively with the migrant problem. Specifically, what these other conditions are I do not know. And even if I thought I knew, it would be more than presumptuous on my part to mention them here. For knowing you as I do, if you have any reasons whatsoever to believe there are others, not only will you determine what they are, but you will do something about them.

In closing, however, I will say that if by chance you do conclude that there are others and find either of them to be a lack of confidence, low socio-economic status, or lack of community acceptance and problems of adjustment, you may find encouragement and strength in a statement made by one of our Nation's greatest statesmen as you develop plans for dealing with them. Having long since been characterized as a man who loved people; who understood them and their desire to get on and up in the world to realize their best selves by doing right and being right, this statesman, while speaking to a group in Springfield, Illinois, more than 125 years ago, had this to say,

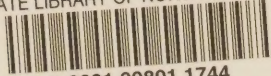
"When one who has long been recognized as a victim of circumstances bursts the fetters that have bound him, and appears before his neighbors clothed in his right mind, and stands up with tears of joy trembling in his eyes to tell of the miseries once endured, now to be endured no more forever; of his once naked and starving children, now clothed and fed comfortably; of his wife long weighted down with a broken heart, now restored to health, happiness, and renewed affection, there is a logic and an eloquence in it that few human feelings can resist.

Effecting this kind of liberation for mankind everywhere is a moral obligation and the combined responsibility of all of us here. And in so doing, it is always to be remembered that: brotherhood of man cannot be furthered by encouraging class hatred; character and confidence cannot be built by taking away one's initiative and courage; and men cannot be helped permanently by doing for them continually those things they can and should do for themselves."

So as we turn to our conference deliberations tomorrow and Sunday, please allow me to commend this concept as a point of view for your consideration. These things I truly believe and this is my challenge

to you at this time. And to our Program Committee--Yes, I agree with you, "Migrants are People."

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